54001. General.

(a) Adult day health care services may be provided to eligible Medi-Cal beneficiaries by adult day health care providers which meet the requirements of this Chapter. Adult day health care providers shall:

(1) Sign an adult day health care provider agreement with the Department to provide the services described under this Chapter to Medi-Cal beneficiaries who are eligible for and voluntarily elect to participate in an adult day health care program.

(2) Promote the social, emotional and physical well-being of impaired individuals living in the community, alone or with others, in order to maintain them at or restore them to their optimal functional potential and to help them remain at or return to their homes.

(3) Share with families and other persons the burden of providing substantial care to impaired elderly individuals by offering respite for one or several days during the week.

(4) Supplement the diagnostic evaluation conducted by other health professionals by means of a sustained functional assessment.

(5) Provide diagnostic and treatment services to persons who would otherwise require admission to or continued stay in a hospital or other health care facility.

54003. Definitions and Standards.

The definitions stated in Article 2, Chapter 3, Division 3, Title 22, California Administrative Code, and the standards stated in Article 3, Chapter 3, Division 3 of the California Administrative Code, shall apply to this Chapter unless modified by regulations in this Chapter.

54005. Grants.

The Department shall grant funds for the establishment of Adult Day Health Centers from the one-time appropriation of $100,000 authorized by Chapter 1065, Statute of 1977. The grants shall be made to licensed centers in accordance with the departmental guidelines for AB 1612, issued January 3, 1978.

54101. Activity Program.

Activity program means a program as defined in Title 22, Division 5, Sections 72381 and 73377, California Administrative Code.

54103. Adult Day Health Care.

Adult day health care means an organized day program of therapeutic, social and health activities and services, provided to elderly persons or other persons with physical or mental impairments for the purpose of restoring or maintaining optimal capacity for self-care.

54105. Adult Day Health Center.

Adult day health center means a licensed facility which provides adult day health care, or a distinct portion of a licensed health facility in which such care is provided in a specialized unit, under a special permit issued by the Department.

54107. Adult Day Health Care County Plan.

Adult Day Health Care County Plan means a county plan for a community-based system of adult day health care.

54108. Adult Day Health Care Planning Council.

"Adult Day Health Care Planning Council" means the council appointed by the county board of supervisors to develop the Adult Day Health Care County Plan.

54109. Affiliate.

Affiliate means an organization or person that, directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with an adult day health care provider and that provides services to an adult day health center.

54111. Beneficiary Agreement of Participation.

Beneficiary agreement of participation means the agreement voluntarily signed by a beneficiary or the beneficiary's guardian or legal conservator in which the beneficiary agrees to receive day health services from the adult day health center.

54113. Day of Attendance.

Day of attendance means any calendar day during which a participant receives covered services at the center for a minimum of four hours, excluding transportation time.

54115. Daily Rate.

Daily rate means the amount paid by the Department per day of attendance to the adult day health center for administration and covered services provided under the adult day health care program.

54117. Discharge.

Discharge means the termination of an agreement of participation.

54119. Individualized Plan of Care.

Individualized plan of care means a written plan designed to provide a participant of an adult day health center with appropriate treatment in accordance with the assessed needs of the participant.

54121. Multidisciplinary Team.

Multidisciplinary team means the group within the adult day health center that conducts assessments and makes recommendations to the Department regarding admission, treatment and services provided, and discharge of participants by the adult day health center.

54123. Nonmedical Transportation.

Nonmedical transportation means the movement of participants to and from the adult day health center in vehicles that are not specially equipped for medical transportation services.

54125. Nutrition Service.

(a) Nutrition service means a service provided by the adult day health center which is organized, staffed and equipped to provide:

(1) Safe, appetizing and nutritional food.

(2) Therapeutic diets prescribed by the participant's physician.

(3) Counseling when therapeutic diets are prescribed.

54127. Nursing Service.

Nursing service means a service provided by the adult day health center which is organized, staffed and equipped to provide skilled nursing care to participants.

54129. Occupational Therapy.

Occupational therapy as used in this Chapter means services rendered by an occupational therapist to train or strengthen muscles or nerve functions. Services shall include, but are not limited to, modification of the environment and training in self-help for activities of daily living.

54131. Participant.

Participant means a Medi-Cal beneficiary who has been accepted by the adult day health center's Intake and Assessment Unit, voluntarily signs an Agreement of Participation, and whose application for participation in an adult day health center has been approved by the Department.

54133. Psychiatric and Psychological Services.

(a) Psychiatric services means services performed by a physician trained or experienced in psychiatry.

(b) Psychology services means services provided by a:
(1) Psychologist.

(2) Psychological assistant under the direction and supervision of a psychologist or board certified psychiatrist.

(3) A psychiatric social worker who is a licensed clinical social worker working in consultation with a psychologist or board certified psychiatrist.

(4) A psychiatric nurse who meets the qualifications of Section 78337.

54135. Service Area.

Service area means the geographic area in which the adult day health center is authorized to provide service. Unless otherwise specified, the service area shall be so limited that no participant will be in transit utilizing ground transportation more than one hour from his or her home to the center.

54137. Staff Physician Services.

Staff physician services means those services provided by a physician employed by the adult day health care provider.

54139. Subcontract.

(a) Subcontract means any agreement between the adult day health care provider and any of the following:

(1) A provider of services, as defined in Section 51051, and any other organization that provides services to Medi-Cal beneficiaries in order to meet the requirements of this Chapter.

(2) An organization or person that performs administrative functions or services for the operation of the program specifically related to meeting the requirements of this Chapter.

54141. Supervision.

(a) Supervision means the instruction and direction of an employee or subordinate in the performance of assigned duties. Supervision does not necessarily require the immediate presence of the supervisor.

(1) Direct supervision means that the supervisor shall be present in the same building as the person being supervised and available for consultation and assistance.

(2) Immediate supervision shall mean that the supervisor shall be physically present while the task is being performed.

54201. Eligibility.

Adult day health care services may be provided to eligible Medi-Cal beneficiaries who have medical or psychiatric impairment, who meet the criteria stated in Section 54209, and who are one of the following:
(a) Not inpatients in a licensed health facility.

(b) Inpatients in a licensed health facility who are provided transition visits in accordance with Section 54504.

54203. Participation.

(a) Participation by an eligible Medi-Cal beneficiary in adult day health care program shall require:

(1) A written request from a physician.

(2) A multidisciplinary team assessment.

(3) An agreement of participation signed by the participant or the participant's guardian or conservator.

(4) Approval by the Department.

54205. Physician Request.

(a) Adult day health care services shall be requested in writing by a physician. The request shall include:

(1) Principal and significant diagnoses.

(2) Prognosis.

(3) Specific type of treatment and anticipated duration.

(4) Overall therapeutic goals for the participant.

(5) Medications and special diets.

54207. Multidisciplinary Team Assessment.

(a) Each applicant shall be assessed by a multidisciplinary team prior to acceptance into the program. The assessment shall be conducted by

the adult day health care provider in order to ascertain the individual's pathological diagnosis, physical disabilities, functional abilities, psychological status and social and physical environment. The assessment shall include:

(1) Contact with the applicant's physician to obtain the individual's medical history and a statement indicating the applicant's restrictions and medications and absence of infectious disease. If the applicant does not have a personal physician, the center shall assist the individual in finding one. An initial physical examination may be done by the staff physician or by a nurse practitioner under the supervision of a physician to the extent allowed under state law.

(2) Assessment of the home environment based on a home visit within the last 12 months. The assessment shall include:

(A) Living arrangements.

(B) Relationship with family or other person.

(C) Facilities available such as heat, bath, toilet, stove.

(D) Existence of environmental barriers such as stairs or other features not negotiable by the impaired individual.

(E) Access to transportation, shopping, church or other needs of the individual.

54209. Prior Authorization.

(a) Adult day health care services except for the initial assessment and reassessments shall require prior authorization by the Medi-Cal Consultant. The request for authorization shall:

(1) Be initiated by the center and shall include the results of an individual's multidisciplinary assessment conducted by the center within the last 30 days and the participant's plan of care.

(2) Be approved and signed by a physician.

(3) Include a statement describing the patient's progress toward achieving the therapeutic goals.

(b) Initial authorizations and reauthorizations may be granted for up to three months. Adult day health centers which do not have a staff physician shall obtain signed approval of the treatment plan every 180 days.

(c) Authorization or reauthorization may be granted only if all of the following conditions exist:

(1) A medical condition that requires treatment or rehabilitative services prescribed by a physician.

(2) Mental or physical impairments which handicap daily living activities but which are not of such a serious nature as to require 24-hour institutional care.

(3) Reasonable expectation that preventative service will maintain or improve the present level of functioning.

(4) High potential for further deterioration and probable institutionalization if adult day health care were not available.

(d) In determining the need for adult day health care services, the Medi-Cal Consultant shall consider the following:

(1) Medical factors including the necessity:

(A) For nursing care, supervision or observation on an ongoing intermittent basis to abate health deterioration.

(B) To see a physician or psychiatrist no less than every 60 days.

(C) To monitor medications for response and effect on an intermittent basis.

(D) For medications which cannot safely be self-administered due to physical or mental disabilities.

(E) For individualized therapeutic treatment designed to restore optimal functional potential or to prevent deterioration.

(2) Functional status including:

Limitation in movement, with or without an assistive device such as a cane, walker, crutches, prosthesis or wheelchair, or the need for training in the use of these devices.

(B) Inability to perform toileting, bathing, eating, dressing, grooming, transferring and self-medication or the need of training and assistance in the activities of daily living.

(C) Incontinency and the probable benefit from continence retraining.

(D) Vision, hearing or sensory loss to some degree.

(E) Dependency and the need for part-time or full-time basic supervision by persons other than day health center staff.

(3) Psychosocial limitations including:

(A) Inability of person or family to cope adequately with problems associated with the person's disability.

(B) Need for a psychosocial environment involving peer group membership and social rehabilitation.

(C) Mild or moderate confusion or depression, or tendency to wander.

(D) Inappropriate affect, appearance or behavior.

54211. Multidisciplinary Team.

(a) The multidisciplinary team conducting the assessment pursuant to Section 54207 shall consist of at least a physician, nurse, social worker, occupational therapist and physical therapist. The physician may be either a salaried staff member of the adult day health center or the participant's physician. When indicated by the needs of the participant, a psychiatrist, psychologist, psychiatric social worker, speech therapist and dietitian shall be included as members of the assessment team and assist in the assessment.

(b) The multidisciplinary assessment team shall:

(1) Determine the medical, psychosocial and functional status of each participant.

(2) Develop an individualized plan of care including goals, objectives and services designed to meet the needs of the person. The plan shall be signed by each member of the team, except that the signature of only one physician member of the team shall be required.

(A) The individualized plan of care shall include:

1. Medical diagnoses.

2. Prescribed medications and frequency.

3. Scheduled days of attendance.

4. Specific type, number of units of service and frequency of individual services to be given on a monthly basis.

5. The specific elements of the services which need to be identified with individual objectives, therapeutic goals and duration of treatment.

6. An individualized activity plan designed to meet the needs of the participant for social and therapeutic recreational activities.

7. Participation in specific group activities.

8. A plan to meet transportation needs.

9. Therapeutic diet requirements, dietary counseling and education if indicated.

10. A plan for other needed services which the adult day health center will coordinate.

11. Prognosis and prospective length of stay.

54213. Discharge.

(a) Participation in an adult day health program shall be voluntary. The participant may terminate participation at any time. However, if the assessment team has found the participant's condition to be of such serious nature that continued treatment is essential to prevent institutionalization, the participant shall be informed in writing that termination is counter to the participant's best interest. A copy of the letter shall be sent to the participant's personal physician and the Department.

(b) Discharge shall be mandatory when:

(1) The participant notifies the adult day health care center either orally or in writing of intent to discontinue participation. The date of discharge shall be the date of notification or a later date designated by the participant.

(2) The participant leaves the service area permanently.

(3) The participant requests discharge from the Department either orally or in writing. The date of discharge shall be as in (1).

(c) Discharge may be requested by the adult day health center if:

(1) Maximum benefit has been achieved and there is no further need for adult day health care services.

(2) The participant is unable or unwilling to use the prescribed services and adult day health center staff have made every effort to remove possible obstacles.

(d) The adult day health center shall forward any discharge request and supporting information to the Department within five working days of receipt.

54215. Reassessment.

(a) Reassessment, at least quarterly, shall include:

(1) Progress achieved.

(2) Review and revision of goals and objectives.

(3) Revision or continuation of the individual plan of care.

(4) Preparation of a reauthorization request for continuing care.

54217. Beneficiary Agreement of Participation.

(a) When the initial assessment has been completed and the individualized plan of care prepared, an agreement of participation on forms furnished by the Department shall be prepared by the adult day health care provider and discussed with the prospective participant or the participant's guardian or conservator.

(b) If the terms of agreement are satisfactory, the participant shall sign the statement. The statement shall be sent to the Department with the initial Treatment Authorization Request. The signing of the agreement of participation does not mandate participation and the participant may end participation at any time.

(c) Statement that the participant understands that services beyond the amounts included in each adult day health center's staffing requirements as set forth in Section 54423 (a) are subject to prior authorization by a Medi-Cal consultant.

54221. Hours of Operation.

(a) Centers shall be open to participants for no less than 6 hours and no more than 12 hours during each calendar day of operation.

(b) Programs will operate at least five days a week. Adjustment may be made in the hours or days of operation:

(1) To accommodate working relatives of participants.

(2) In response to other special circumstances.

(c) New programs may be initiated with fewer than six hours per day or less than five days per week for the first six months of operation or until full licensed capacity is reached, whichever occurs first.

(1) An adult day health care provider shall not operate less than five days a week or six hours a day after the first six months of operation without written prior approval of the Department. The Department shall consider the following factors in making its decision:

(A) Location of the center.

(B) Density of population.

(C) Average daily attendance.

(D) Availability of transportation and meals from other agencies.

(E) Needs of the participants currently served at the center.

(2) Minimum operation after the sixth month shall be not less than four hours a day and three days a week.

54223. Attendance.

(a) Attendance shall be regular and planned. Treatment needs of the participant shall determine the frequency and duration of attendance. The number of days scheduled shall be governed by the least time needed to carry out an individual plan of care related to the needs of the participant and his or her family.

(b) Participants shall not be encouraged to attend more frequently than necessary for achievement of individual goals and objectives.

54301. Certification.

(a) Each adult day health center shall:

(1) Be licensed or have a special permit pursuant to Chapter 3.5, commencing with Section 1570, Division 2, Health and Safety Code, to provide adult day health care.

(2) Have appropriate licensed and allied health personnel to provide services in accordance with the requirements of this Chapter.

(3) Have a written description of its philosophy, objectives and program for providing medical and ancillary health related services available for public inspection.

(4) Demonstrate to the satisfaction of the Department that staff and facilities are adequate to provide the planned services described in its written program.

(5) Provide or arrange for, through written agreement, nonroutine medical services which may become necessary.

(6) Execute a written agreement with each participant which specifies but is not limited to, a list of basic services which are to be furnished each visit or according to a specified schedule.

(7) When serving a substantial number of participants of a particular racial group, or whose primary language is other than English, employ staff of that particular racial or linguistic group at all times.

(b) Each facility shall sign an adult day health care provider agreement with the Department in order to participate in the Medi-Cal program.

(c) The Department shall certify adult day health centers which meet the requirements of this chapter as a special category of clinic and hospital outpatient services.

54303. Denial of Initial Certification.

(a) The Director shall deny application for certification if the applicant has:

(1) Not been approved as a licensed adult day health care provider.

(2) Failed to meet the requirements of Section 54301, or any other applicable requirements of the statutes or regulations relating to the California Medical Assistance Program.

(3) Previously violated Department regulations and there is probability of noncompliance by the applicant.

(4) Failed to correct violations of regulations pertaining to licensure or Medi-Cal certification.

(5) Failed to comply with the approved adult day health care county plan.

(b) Upon the denial of the application, a written notice of denial shall be sent by the Department by certified mail informing the applicant of the reasons for denial, and advising the applicant of the right to petition for a hearing.

(c) An applicant may submit a written petition for hearing to the Department within 15 days after the Department mails the notice.

(d) The hearing shall be initiated by filing and serving a statement of issues in accordance with Section 11504.

(e) The proceeding shall be conducted in accordance with Chapter 5, commencing with Section 11500, Division 3, Title 2, Government Code.

(f) Hearing concerning denial of Medi-Cal certification as a provider of adult day health care services shall be consolidated with hearing concerning denial of licensure whenever possible.

54305. Termination or Suspension of Certification.

(a) Certification shall be suspended or revoked for any of the following:

(1) Violation of any statute or regulation relating to the California Medical Assistance Program.

(2) Aiding, abetting or permitting the violation of applicable statutory provisions or regulations of the Department.

(3) Conduct in the operation or maintenance of an adult day health center which is inimical to the health, morals, welfare or safety of either participant receiving services from the center or the people of the State of California.

(b) Proceedings for termination or suspension shall be commenced in accordance with Chapter 5, commencing with Section 11500, Part 1, Division 3, Title 2, Government Code.

54307. Denial of Renewal of Certification.

(a) The Director shall deny an application for renewal of certification as a provider of adult day health care services if the applicant:

(1) Was party to an action which resulted in denial, suspension or revocation of license as an adult day health care provider.

(2) Is not currently certified as a Medi-Cal provider because of suspension or disapproval of an application for certification.

(3) Has previously violated Department regulations and there is probability of noncompliance by the applicant.

(4) Has failed to correct violation of regulations pertaining to other licensure and Medi-Cal certification.

(5) Is not in compliance with the approved Adult Day Health County Plan.

(6) Would be denied certification under Section 54303.

(b) A public hearing may be held in accordance with Section 78215, Division 5, on a renewal application if the Director determines that the public's interest will be served.

(c) The Director shall send the applicant a written notice of denial by certified mail. The notice shall advise the applicant concerning the reason for the denial and the right to petition for a hearing as set forth in Section 54303.

(d) The applicant shall submit a plan and date for discontinuing care to the Director for approval. The Director shall approve the plan in writing.

(e) Hearing concerning denial of renewal application for certification as an adult day health care provider shall be consolidated with any hearing concerning denial of licensure as an adult day health care provider, whenever possible.

54307. Denial of Renewal of Certification.

(a) The Director shall deny an application for renewal of certification as a provider of adult day health care services if the applicant:

(1) Was party to an action which resulted in denial, suspension or revocation of license as an adult day health care provider.

(2) Is not currently certified as a Medi-Cal provider because of suspension or disapproval of an application for certification.

(3) Has previously violated Department regulations and there is probability of noncompliance by the applicant.

(4) Has failed to correct violation of regulations pertaining to other licensure and Medi-Cal certification.

(5) Is not in compliance with the approved Adult Day Health County Plan.

(6) Would be denied certification under Section 54303.

(b) A public hearing may be held in accordance with Section 78215, Division 5, on a renewal application if the Director determines that the public's interest will be served.

(c) The Director shall send the applicant a written notice of denial by certified mail. The notice shall advise the applicant concerning the reason for the denial and the right to petition for a hearing as set forth in Section 54303.

(d) The applicant shall submit a plan and date for discontinuing care to the Director for approval. The Director shall approve the plan in writing.

(e) Hearing concerning denial of renewal application for certification as an adult day health care provider shall be consolidated with any hearing concerning denial of licensure as an adult day health care provider, whenever possible.

54309. Required Services.

(a) Each adult day health center shall provide directly on the premises, at least the following services:

(1) Rehabilitation services, including:

(A) Physical therapy as specified in Section 54313.

(B) Occupational therapy as specified in Section 54315.

(C) Speech therapy as specified in Section 54317.

(2) Medical services supervised by either the participant's personal physician or a staff physician or both.

(3) Nursing service, including:

(A) Skilled nursing care rendered by a professional nursing staff, who evaluate the particular nursing needs of each participant and provide the care and treatment indicated.

(B) Self-care training and services oriented toward activities of daily living and personal hygiene, such as toileting, bathing and grooming.

(4) Nutrition services, including:

(A) A minimum of one meal per day which is in accordance with the requirements stated in Section 54331. Therapeutic diets and supplemental feedings shall be available if therapeutically indicated.

(B) Dietary counseling and nutrition education for participants and their families.

(5) Psychiatric and psychological services including:

(A) Consultation.

(B) Individual assessment.

(C) Supervision of treatment by a psychiatrist, psychologist, psychiatric social worker or psychiatric nurse, when indicated.

(6) Medical social services to participants and their families to help with personal, family and adjustment problems that interfere with the effectiveness of treatment.

(7) Planned recreational and social activities suited to the needs of the participants and designed to encourage physical exercise to prevent deterioration and to stimulate social interaction.

(8) Nonmedical and medical transportation service for participants, only if necessary, to and from their homes. Specially equipped vehicles shall be utilized when medically necessary to accommodate participants with severe physical disabilities that limit mobility.

54311. Optional Services.

(a) Each adult day health center may arrange for the following additional services. These services shall be separately billed by the provider according to the requirements of Article 7, Chapter 3, Division 3, Title 22, California Administrative Code.

(1) Podiatric services arranged for by the supervising physician.

(2) Visual care screening and advice for low-vision cases by a licensed ophthalmologist or optometrist, following referral and arrangement by the supervising physician.

(3) Dental screening for the purpose of apprising the participant of the necessity of regular or emergency dental care, which is arranged for by the supervising physician.

(b) Optional services may include other services within the concept and objectives of adult day health care that have been approved by the Department.

54313. Physical Therapy Service.

(a) The physical therapy service shall:

(1) Provide:

(A) Muscle, nerve joint and functional ability tests.

(B) Treatment to relieve pain, develop or restore function.

(C) Assistance to achieve and maintain maximum performance using physical means such as exercise, massage, heat, sound, water, light or electricity.

(2) Provide an evaluation by the physical therapist and establishment of a treatment program. The treatment program shall be modified as needed based upon subsequent reevaluations.

(3) Require that physical therapists:

(A) Record treatments, each day, in the participant's health record. Each entry shall be signed.

(B) Record quarterly progress notes. Each entry shall be signed and dated.

(C) Review and initial all evaluations and the discharge summary .

(4) Define the responsibilities of the physical therapist and the duties assigned to the auxiliary personnel by the individual treatment plan.

(b) Physical therapy staff shall meet the following requirements:

(1) The physical therapist, physical therapist assistant and physical therapist aide shall accomplish those tasks required by the individualized plan of care within the staffing requirements stated in Section 54423.

(2) The physical therapist shall act as a member of the assessment team in an evaluation of the patient's rehabilitation potential.

(c) Physical therapy equipment shall include but is not limited to:

(1) Parallel bars.

(2) Full-view mirror.

(3) Overhead pulley and weights.

(4) Set of training stairs.

(5) Treatment table enclosed for privacy.

(6) Availability of wheelchairs, walkers, canes, crutches and other ambulation aides.

(d) Adequate space shall be maintained for the necessary physical therapy equipment. Space can be used for other services during the day when physical therapy services are not being given.

(e) Physical therapy procedures may include:

(1) Therapeutic exercise.

(2) Neuromuscular reeducation.

(3) Rehabilitation services.

(4) Functional activities.

(5) Gait training.

(6) Orthotics training.

(7) Prosthesis training.

(8) Massage.

54315. Occupational Therapy Services.

(a) Occupational therapy services shall:

(1) Reevaluate the participant as the condition changes and modify treatment goals consistent with these changes.

(2) Decrease or eliminate disability during participant's initial phase of recovery following injury or illness.

(3) Increase or maintain the participant's capability for independence.

(4) Enhance the participant's physical, emotional and social well-being.

(5) Develop function to a maximum level.

(6) Guide participants in the use of therapeutic, creative and self-care activities for improving function.

(7) Require that occupational therapists:

(A) Record treatments, each day, in the participant's health record. Each entry shall be signed.

(B) Record quarterly progress notes. Each entry shall be signed and dated.

(C) Review and initial all evaluations and the discharge summary.

(8) Develop personnel policies which define the occupational therapy responsibilities and the duties assigned to the occupational therapy assistant.

(b) Occupational therapy staff shall meet the following requirements:

(1) The occupational therapy service shall be under the direction of an occupational therapist.

(2) The occupational therapist and occupational therapy assistant shall work the hours necessary to accomplish those tasks required by the individualized plan of care within the staffing requirements stated in Section 54423.

(c) The occupational therapy service shall provide:

(1) Equipment and supplies for creative skills. This may include, but is not limited to leatherwork, weaving, needlework, ceramics, woodworking, painting and graphic arts.

(2) Means and supplies for adapting equipment for reeducation in activities of daily living.

(3) Therapeutic exercises, sensory stimulation and coordinating exercise concentrating on the range of motion of the upper extremities.

(4) Evaluation of needed splints or slings to increase or maintain functional use of the upper extremities.

(d) Adequate space shall be provided for the necessary occupational therapy equipment needed to provide occupational therapy. Space can be used for other services during times when occupational therapy services are not being given.

54317. Speech Therapy Services.

(a) Speech therapy services shall:

(1) Evaluate participants and develop necessary plans for appropriate speech and language therapy.

(2) Instruct other health team personnel and family members in methods of assisting the participant to improve and correct speech disorders.

(3) Require that speech therapists:

(A) Record treatments, each day, in the participant's health record. Each entry shall be signed.

(B) Record quarterly progress notes. Each entry shall be signed and dated.

(C) Review and initial all evaluations and the discharge summary.

(4) Develop personnel policies which define the duties of the speech therapist and allied personnel.

(b) Speech therapy staff shall meet the following requirements:

(1) There shall be a speech therapist employed a sufficient number of hours to accomplish those tasks listed in each individualized plan of care within the staffing requirements stated in Section 54423.

(2) The speech therapist shall act as a member of the assessment team and evaluate to determine the type of speech or language disorder.

(c) Speech therapy equipment, tests, materials and supplies shall be sufficient to implement the treatment and program required by each participant seen by the speech therapists.

(d) Speech therapy space shall be adequately free of ambient noise.

54319. Staff Physician Services.

(a) Staff physician services shall include consultation to staff and may include the following limited direct services to the participant:

(1) Periodic physical examination as part of the assessment process.

(2) Consultation with the participant's physician.

(3) Minor, incidental or occasional treatment.

(4) The development of the medical component of the individual participant's plan of care, except when this component is developed by the participant's physician who retains primary responsibility for all medical care provided to the participant.

(b) The center staff physician may sign the authorization request and the individualized plan of care.

(c) By arrangement with the center director, staff physician services shall be provided at the center on a regular basis. Staff physician services may be secured on a voluntary basis or may be paid by the adult day health center on an hourly basis consistent with reasonable reimbursement for similar consultative services.

(d) Space shall be provided which ensures privacy for the staff physician's examination and consultation.

(e) The adult day health center may allow participants who are independently responsible for taking their own medication at home, if authorized by the participant's physician, to continue to be responsible for taking their own medication during the hours spent in the adult day health care program.

54321. Personal Physician.

(a) Close liaison shall be maintained with the participant's personal physician. The personal physician shall retain primary responsibility for the medical care of the participant.

(b) The personal physician shall be:

(1) Requested to provide the report of physical examination and medical history required for initial evaluation.

(2) Requested to sign the Medi-Cal treatment authorization request for prior authorization if the adult day health center does not have a staff physician.

(3) Informed, on a regular basis, of the participant's status and progress.

(c) Reimbursement for services provided by a personal physician to a participant shall neither be made by nor become the responsibility of the center.

54323. Nursing Service.

(a) The nursing service shall, as a minimum:

(1) Assess each participant to determine needs for personal care and assistance in activities of daily living such as bathing, grooming, toileting and eating; include these needs in the plan of care and supervise the provision of these services.

(2) Specify short-term and long-term nursing goals in each individualized plan of care.

(3) Document all skilled nursing care provided on the day the service is given and include quarterly signed and dated progress notes in each participant record.

(4) Provide health education and counseling to the participant and family when indicated by the plan of care.

(5) Provide assistance to the participant in obtaining medical services from providers other than adult day health staff.

(6) Monitor, administer and record prescribed medications as follows:

(A) Medication shall be given only on the prescriber's order.

(B) Participants shall be identified prior to the administration of a drug.

(C) Medication shall be administered within one hour of the prescribed time.

(D) Time and doses of each drug administered must be recorded in the participant's record by the nurse who gave the drug.

(7) Provide training in self-administration of medications to participants.

(8) Provide liaison to the participant's personal physician.

(9) Develop the nursing component in the plan of care for each participant capable of benefiting from a continence training program.

(10) Provide observation and monitoring of health status.

(11) Provide supportive and restorative nursing as indicated by the treatment plan.

(b) The nursing service shall provide a registered nurse or a licensed vocational nurse under the supervision of a registered nurse at the center during the hours the center is offering required services.

(c) A registered nurse shall be a member of the assessment team to assess the nursing needs of the participant and develop the nursing component of the individualized plan of care.

(d) Nursing service supplies and equipment shall meet the requirements of Section 78439 (a), Title 22, California Administrative Code.

54325. Psychiatric and Psychological Services.

(a) Each adult day health center shall have a consultant psychiatrist, psychologist, psychiatric social worker or psychiatric nurse who shall make assessments of participants when indicated, develop an individualized plan of care, supervise the carrying out of these plans and do reassessments. The consultant psychiatrist, psychologist, psychiatric social worker or psychiatric nurse shall provide consultation services to center staff at least three hours per month.

(b) Consultant services are indicated when:

(1) The participant's diagnoses or medical history indicate a mental, emotional or behavioral problem.

(2) Information from the participant's family indicates mental, emotional or behavioral problems may exist.

(3) The psychosocial assessment developed by the social worker indicates apparent mental, emotional or behavioral problems that need further assessment by a psychiatrist, psychologist, psychiatric social worker or psychiatric nurse.

(4) Observation by center staff indicates the need for psychiatric or psychological assessment.

(c) Services shall provide a therapeutic setting conducive to restoring dignity and self-esteem and good mental health to all participants. Techniques such as group socialization activities which restore or expand normal social roles, individual and group therapies in various forms such as reality orientation, art and music therapy, psycho-social drama, counseling and discussion shall be a part of the general program. Specialized techniques and mental health treatment supervised by a psychiatrist, psychologist or psychiatric social worker may be provided as part of the plan of care by appropriately qualified personnel.

54327. Personal Psychiatrist and Psychologist Services.

(a) The adult day health center shall maintain close liaison with the attending psychologist or psychiatrist providing services to a participant. The psychologist or psychiatrist shall maintain primary responsibility for the psychological or psychiatric treatment of the participant and shall be kept informed of the participant's health status. Any psychologic or psychiatric services provided by the center shall be coordinated with the attending psychiatrist or psychologist.

(b) The center shall assist the participant in obtaining psychiatric or psychological services determined to be necessary.

(c) An attending psychiatrist or psychologist for an individual participant who is also the consultant psychiatrist or psychologist for the adult day health center, may not bill for services provided at the center for this participant in the manner prescribed in Article 7, Chapter 3, Division 3, Title 22, California Administrative Code.

54329. Medical Social Services.

(a) Medical social services shall as a minimum:

(1) Interview and screen all referrals to determine the general appropriateness of the prospective participant for the full assessment process and adult day health care participation.

(2) Provide referral for persons not appropriate for adult day health care.

(3) Provide a signed and dated documentation for all service performed the day the service is provided and include signed and dated quarterly progress reports in each participant record.

(4) Provide for periodic reevaluation and revision of plan of care.

(5) Provide counseling and referral to available community resources.

(6) Promote peer group relationship through problem-centered discussion group and task oriented committees.

(7) Serve as liaison with the participant's family and home.

(8) Serve as liaison with other community agencies who may be providing services to a participant and work with these agencies to coordinate all services delivered to the participant to meet the

participant's needs and avoid duplication. Liaison shall include, but not be limited to the following agencies:

(A) In-Home Supportive Services in the county welfare department.

(B) Home Health Agency providers.

(9) Provide discharge planning for all discharged participants.

(b) Medical social service staffing shall meet the following requirements:

(1) A medical social worker shall be a full-time employee of the adult day health center.

(2) A social work assistant or social work aide shall provide medical social services only under the supervision of the medical social worker.

(3) A medical social worker shall act as a member of the assessment team to evaluate medical social needs of all participants. The medical social worker shall develop a plan of care if indicated, including short-term and long-term goals with participation of the participant's family and other appropriate individuals.

54331. Nutrition Service.

(a) The nutrition service shall as a minimum:

(1) Be staffed and equipped to assure that food provided to the participants is safe, appetizing and provides for nutritional needs.

(2) Include dietary counseling and education as part of the nutrition service.

(3) Provide at least one meal to each participant who is present for four hours. The meal shall provide one-third of the recommended dietary allowance of the Nutrition Board of the National Research Council, National Academy of Science.

(4) Each participant who is in the center for eight hours shall be served a meal and between meal nourishments that shall supply at least one-half of the recommended dietary allowance of the Nutrition Board of the National Research Council, National Academy of Science.

(b) Participant food preferences, including ethnic foods shall be adhered to as much as possible.

(c) Therapeutic diets shall be served as ordered and shall be prepared under the guidance of a registered dietitian. The diet order shall be reviewed every 90 days when the reassessment is done.

(d) A dietitian shall be employed on a consulting basis. Consultant services shall be provided on the premises at appropriate times on a regularly scheduled basis. A written record of the frequency, nature and duration of the consultant's visits shall be maintained.

(e) Sufficient staff shall be employed, oriented, trained and their working hours scheduled to provide for the nutritional needs of the participants and to maintain the service areas. If nutritional employees are assigned duties in other services, those duties shall not interfere with the sanitation, safety or time required for work assignments.

54333. Transportation.

(a) Transportation shall be provided only if necessary. Persons who live within walking distance of the center and who are sufficiently mobile shall be encouraged to walk to the center.

(b) Family members shall be encouraged to provide nonmedical transportation for the participant if specially equipped vehicles are not needed. Volunteers may also be utilized to provide transportation.

(c) Transportation to and from participants' homes shall be scheduled to insure that participant one-way transit time does not exceed one hour.

(d) Medical transportation shall be supplied by either the center's own vehicles or by contract with other transportation services to facilitate regular attendance and prompt arrival and departure. If there is an existing transportation system in the area which is equipped to handle handicapped persons and is capable of providing the level of service, medical transportation service shall be purchased from that system. Vehicles used for nonmedical transportation shall be in good condition. Vehicles used for medical transportation shall meet the qualifications stated in Section 51151 .

(e) Vehicle operators employed by the center shall maintain good driving records and shall have an appropriate operator's license. The vehicle operator shall be responsible for maintaining a schedule of transportation to and from the center. The driver or the driver's assistant shall assist the participant in and out of home and vehicle as necessary.

(f) If a participant does not appear for transportation or come to the center on a scheduled day of attendance, prompt follow-up shall be made to determine the reason. Efforts should be made to determine if the participant is helpless and unable to answer the door or phone or has gone away for the day.

(g) Participants who know that they will not attend on a scheduled day, shall notify the center.

(h) If the participant is ill, the adult day health center shall determine by visit or by telephone call the extent of the illness and make arrangements for proper treatment if indicated, such as notifying the participant's physician, family or arranging for home health services.

54335. Emergency Service.

(a) Each adult day health center shall provide a readily available source of emergency health services.

(1) The participant, or the participant's sponsor shall sign an agreement granting the center permission to transfer the participant to a hospital or other health facility in case of emergency.

(2) The center shall maintain written agreements for emergency medical care which shall include:

(A) An on-call physician.

(B) Hospital or emergency room care.

(C) Medical transportation.

(b) First aid services shall be available. All staff members shall receive in-service training in first aid and cardiac pulmonary resuscitation within the first six months of employment. Annual refresher courses shall be arranged for by the adult day health provider.

54337. Program Aides.

(a) Program aides may be full-time or part-time employees. Aides shall evidence capacity for learning, the ability to comprehend the use of written and spoken English and shall have personal qualities conducive to good interpersonal relationships with demonstrated competence in helping others.

(b) Program aides, under the supervision of the program director or of members of the multidisciplinary assessment team, shall perform assigned tasks involving:

(1) Support of major group activity and recreational programs.

(2) Transportation of participants to and from the adult day health center.

(3) Arranging for appointments for participants outside the center.

(4) Assistance in personal care under nursing supervision.

(c) Program aides may be part-time or full-time volunteers serving without compensation. Volunteer participation shall be encouraged. Volunteer staff shall not be considered in the basic staff ratio. Regular individual hours of service shall be scheduled to the mutual satisfaction of volunteers and staff. Volunteers shall be responsible to the program director or a delegated staff member.

(d) The duties of volunteers shall be mutually determined by volunteers and staff and shall either supplement staff in established activities or by providing additional services to the program for which the volunteer has special talents, such as but not limited to:

(1) Art.

(2) Music.

(3) Flower arrangements.

(4) Foreign language.

(5) Creative skills or crafts.

54339. Activity Program.

(a) The activity program shall be staffed and equipped to meet the needs and interests of each participant and shall encourage self-care and resumption of normal activities. Participants shall be encouraged to participate in activities suited to their individual needs. The activity program shall provide a planned schedule of social and other

purposeful independent or group activities. Opportunities shall be provided for involvement, both individual and group, in the planning and implementation of the activity programs.

(b) The primary objectives of activity programs shall be to encourage the participant toward restoration to self-care and the resumption of normal activities or for those who cannot realistically resume normal activities, to prevent further mental or physical deterioration.

(c) The individual plan of care of each participant shall include an individual activity plan. This plan shall be reviewed quarterly.

(d) Each adult day health center shall designate an activity coordinator who shall be a full-time employee of the center. The activity coordinator shall have the following duties:

(1) Assess the needs and interests of each participant and develop an individualized activity plan as part of the individualized plan of care developed by the assessment team.

(2) Record, date and sign quarterly progress notes in each participant record.

(3) Provide or supervise the provision of activities specified in the activity plan.

(4) Develop, implement and supervise the activity program.

(5) Schedule and post planned activities.

(e) The center shall provide equipment and supplies necessary for the program, including special equipment and supplies necessary for participants having special needs.

54401. Organization and Administration.

(a) Each adult day health center shall be organized and staffed to carry out the requirements of this Chapter. Staffing and administrative requirements and capabilities shall include:

(1) An administrator.

(2) A program director with appropriate qualifications.

(3) Sufficient clerical supportive staff to conduct the center's daily business in an orderly manner.

(4) A grievance procedure.

(5) The ability to provide data reports required by the Department.

(6) Financial records and books of account fully disclosing the disposition of all funds received. Fiscal reports shall be submitted quarterly to the Department in the format prescribed by the Department.

(7) Appropriately qualified staff in sufficient numbers to provide an adequate scope of services and to meet the staffing requirements stated in Section 54423.

(8) Ethnic or linguistic staff as indicated by participant characteristics.

(9) Participant records maintained in a format approved by the Department.

(10) Adequate personnel records.

(11) Nondiscrimination by and to participants and staff.

(12) Confidentiality of data maintained as stated in Section 54439.

(b) Each adult day health care provider shall establish written policies and procedures for continuously reviewing the performance of health personnel, the utilization of services, costs and standards for acceptable health care. Such procedures shall receive prior approval of the Department.

54403. Administrator.

(a) Each center shall have an administrator. The administrator shall have the responsibility and authority to carry out the policies of the licenses. The licensee shall notify the Department in writing within 14 working days following a change of administrator. Notification shall include the new administrator's name, mailing address, effective date of office, background, qualifications and Social Security number.

(b) An administrator shall have the following qualifications:

(1) Knowledge of supervision and care appropriate to the participants receiving services.

(2) Ability to conform to the applicable laws, rules and regulations.

(3) Ability to maintain or supervise the maintenance of financial and other records.

(4) Ability to direct the work of others.

(5) Be of good character and maintain a reputation of personal integrity.

(6) Graduation from an accredited college or university, in a field related to the program, and either of the following:

(A) A master's degree plus one year of successful experience in a responsible managerial, administrative or supervisory position in a social or health service program or agency.

(B) A bachelor's degree plus three years of successful experience in a responsible managerial, administrative or supervisory position in a social or health service program or agency.

(c) The administrator shall:

(1) Administer the center in accordance with these regulations and established policy, program and budget.

(2) Report to the licensee concerning the operation of the center and interpret recognized standards of care and supervision to the licensee.

(3) Develop an administrative plan and procedure to insure clearly defined lines of responsibility, equitable workloads and adequate supervision.

(4) Recruit, employ and train qualified employees and terminate employment of employees who perform in an unsatisfactory manner.

(d) Each center shall make provision for continuity of operation and assumption of the administrator's responsibilities during the administrator's absence.

(e) Centers with a capacity of 50 and over, shall provide both an administrator and a full-time program director.

(f) The administrator of two or more licensed centers shall not serve as a program director.

(g) The administrator shall not be responsible for more than three centers, without prior written approval by the Department. In this circumstance, there shall be one assistant administrator for every three additional centers or fraction thereof.

54405. Program Director.

(a) Each center shall have a full-time program director during hours of operation. The administrator may serve in this capacity if the administrator meets the qualifications. The program director shall be on the premises and available to participants and their relatives and employees. When the program director is temporarily absent, another adult on the staff shall be designated to serve as the acting program director. When the program director is expected to be or has been absent for more than one month, the acting program director shall meet the qualifications of the program director.

(b) The program director shall be a qualified professional in the field of nursing, social work, psychology or recreational, occupational or physical therapy with demonstrated or potential competence in working with the impaired, elderly living at home. The director shall be knowledgeable of physical, social and mental health programs operating within a licensed health facility or clinic. The director shall have no other duties than those related to adult day health care and during those hours shall not be included in the staff ratios of any other licensed facility.

(c) The duties of the program director shall include:

(1) Developing the program in accordance with the needs of the participants served.

(2) Implementing and coordinating the program.

(3) Evaluating the participant's changing needs and making necessary program adjustments.

(4) Supervising employees and volunteers.

54406. Activity Coordinator.

(a) The activity coordinator shall have one of the following qualifications:

(1) Two years' experience in a social recreational or educational program within the past five years, one year of which was full-time in an activities program in a health care, mental health or handicapped program setting.

(2) Be an occupational therapist, art therapist, music therapist, dance therapist, recreation therapist, occupational therapist assistant or qualified social worker.

(3) Completion of at least 36 hours training in a course designed specifically for this position and approved by the Department and shall receive regular consultation from an occupational therapist, qualified social worker or recreation therapist.

54407. Grievance Procedure.

(a) Each adult day health care provider shall establish and maintain a procedure for submittal, processing and resolution of grievances of participants regarding care and administration by the provider. Such procedure shall be approved by the Department and shall provide for the following:

(1) Recording each grievance in writing.

(2) Maintaining a log of all grievances submitted, including notes on progress towards resolution.

(3) A written finding of fact and decision within 30 days of the recording of any grievance received.

(4) Transmittal of the following to the participant within five days of decision:

(A) A written copy of the finding of fact.

(B) An explanation of the decision concerning the grievance.

(C) Information concerning the participant's right to a fair hearing in accordance with Section 54409.

(b) The participant may request a fair hearing by the Department within 10 days following receipt of written decision concerning the grievance.

54409. Participant Fair Hearing.

(a) Each participant shall have the right to a fair hearing for matters relative to an unresolved grievance regarding care and administration by the adult day health care provider.

(b) The adult day care provider shall present its position at the fair hearing and implement the fair hearing decision adopted by the Director.

(c) Implementation of the fair hearing decision shall not be the basis for discharge of the participant by the adult day health care provider.

54411. Reports.

(a) Each provider of adult day health care services shall furnish to the Director or the Director's designee scheduled or requested information and reports including but not limited to information and reports listed below:

(1) Monthly Services Report for each participant.

(2) Agreements of Participation.

(3) Discharge requests.

(4) Initial and successive individualized plans of care.

(5) Treatment Authorization Request.

(6) Annual demographic report.

(7) Financial Reporting.

(8) Any other reports requested by the Department.

54413. Financial Reporting.

(a) The adult day health care provider shall maintain financial records on an accrual basis and shall submit to the Department an annual audit performed by an independent certified public accountant . All verified

financial statements shall be filed with the Department as soon as practical after the close of the center's fiscal year, and in any event, within a period not to exceed 90 days thereafter. The Department may grant exceptions to this time limit, for good cause.

(b) The audit report prepared by the independent certified public accountant shall include a table of contents and at least the following:

(1) A balance sheet reflecting the assets, liabilities and net worth of the adult day health care provider at the close of the fiscal year under audit.

(2) A statement of income and expenses reflecting all sources and amounts of income and expenses.

(3) A statement of changes in financial position, reflecting the adult day health care provider's sources and applications of funds and the net increase or decrease in working capital for the fiscal year just ended.

(4) All notes relating to the financial statements specified in (1), (2) and (3).

(5) A statement that the audit was conducted in accordance with generally accepted auditing standards and, further where in the accountant's opinion, the financial statements fairly present the financial position, results of operations and changes in financial position in conformity with generally accepted accounting principles applied on a consistent basis. If the accountant is unable to express an unqualified opinion, this shall be stated in his report and the report shall specify the reason or reasons.

(6) Financial statements shall be public records.

(c) Upon the Department's written request, the adult day health care provider shall authorize the accountant to allow representatives of the Department to inspect any and all working papers relating to the preparation of the audit report, including notes, computation, work sheets and rough drafts at the accountant's place of business during normal business hours. The accountant's costs of producing records for inspection and the costs incurred in the reproduction of documents shall be borne by the Department.

(d) When delivery of adult day health care is dependent in part upon affiliates, combined financial statements shall be prepared, and as a minimum disclose:

(1) The financial position of the provider separate from the combined totals.

(2) Inter-entity adjustments and eliminations.

(3) An independent accountant's opinion in writing, indicating why combined statements are not appropriate.

(e) A quarterly report shall be submitted by the center to the Department. The report shall include:

(1) A balance sheet.

(2) Revenue and expenses by cost center, including but not limited to salaries and staff benefits by work classification, equipment, contracts, consultation, training and travel. Cost centers shall include:

(A) Medical and nursing.

(B) Physical therapy.

(C) Occupational therapy.

(D) Speech therapy.

(E) Psycho-social services.

(F) Nutrition.

1. Transportation incidental to provision of meals.

2. Nutritional counseling.

(G) Supportive services.

1. Recreation.

2. Art, music and dance therapy.

3. Services not included in other cost centers.

(H) Administration.

1. Office supplies and equipment.

2. Postage.

3. Furniture.

4. Publications and printing.

5. Liability insurance.

6. Telephone, telegraph.

7. Reproduction.

8. Legal consultation.

9. Audit expenses.

10. Rent.

11. Utilities.

12. Maintenance.

(I) Space.

1. Rent or mortgage payment.

2. Facility insurance.

3. Utilities.

4. Housekeeping supplies and equipment.

5. Maintenance supplies and equipment.

6. Repairs.

7. Facility license fees.

8. Janitorial service.

(J) Transportation.

1. Insurance.

2. Parking fees.

3. Overnight storage fees.

4. Vehicle license fees.

5. Purchased transportation services.

6. Vehicle supplies.

7. Vehicle maintenance.

8. Amortization.

(2) Such financial records shall be filed with the Department as soon as practical after the end of the licensee's fiscal quarter and, in any event, within a period not to exceed 30 days thereafter.

(f) Every affiliated company shall:

(A) Furnish, upon request, to the provider and to the Department financial reports relevant to the disposition of funds paid to the affiliated company by the provider. Reports shall be:

1. Prepared in accordance with generally accepted accounting principles.

2. Provide all financial data required by provider to fulfill its obligations to the Department for financial reporting.

(B) Make all books and records available for inspection by the Department and the United States Department of Health, Education and Welfare for a term of at least four years.

(g) Each adult day health provider shall maintain adequate financial resources to carry out its obligations. The level of such resources shall be determined for each provider by the Department and shall include, but will not necessarily be limited to, the following:

(1) Ability to meet current obligations when due.

(2) Revenue and expense trends.

54415. Medical Review.

(a) Each adult day health care center shall be reviewed by a Department of Health medical review team at least annually. The review shall include but is not limited to assessment of:

(1) The participant's current medical, psycho-social and functional status.

(2) The appropriateness of care provided.

(3) The quality of care provided.

(4) The necessity for the services rendered.

(5) Staffing requirements.

(6) The system for participant care.

(7) Medical records.

(8) Professional review system and reports.

(9) Grievances relating to health care and their disposition.

(10) Procedures for controlling the utilization of services.

54417. On-Site Visits.

(a) Each adult day health care center shall be subject to periodic on-site visits by Department representatives. Such visits shall include but are not limited to observation of the following:

(1) General operation.

(2) Availability and provision of services.

(3) Degree of participant satisfaction with the adult day health care center.

(4) Administrative operation.

s 54419. Utilization Review Committee.

(a) Each adult day health center shall establish a utilization review committee. Membership in this committee shall include, but is not limited to, a representative from the adult day health center, and professional personnel such as a physician, psychiatrist, nurse, social worker, occupational, physical or speech therapist who are not employed by the center.

(b) The committee shall evaluate the appropriateness of the health care provided by reviewing individual records of participants and shall make recommendations to the center to correct any deficiencies identified. Procedures for the utilization review committee and the method of selecting records for review shall be approved by the Department. This committee shall meet at least quarterly.

(c) All activities of the utilization review committee shall be reported quarterly to the Department in a format approved by the Department. As a minimum, the report shall include the:

(1) Number of cases reviewed.

(2) Nature and extent of the problems encountered.

(3) Summaries of the actions taken by the review system.

(d) Each provider of adult day health care services shall permit the Department and the Department of Health, Education and Welfare to inspect, audit and otherwise, evaluate the quality and appropriateness of care being rendered to participants served by the center.

54421. Advisory Committees.

(a) Each adult day health care center may establish an advisory committee composed of community and participant representatives other than those comprising the governing body. The functions of this committee shall be:

(1) To serve as informational resources.

(2) To provide liaison between the center and the community.

(3) To resolve individual issues.

(4) To contribute specific expertise as needed.

(5) To assist in reaching those in need of services.

(b) The committee may meet monthly.

54423. Staffing Requirements.

(a) The program director, a registered nurse with public health background, a medical social worker, a program aide and the activity coordinator shall be on duty. Other staff shall be employed in sufficient numbers to provide services as prescribed in the individual plans or care, in accordance with the following minimal requirements, determined by each center's average daily attendance based on the previous quarter experience.

(1) Centers with an average daily attendance of 10 or less shall provide at least:

(A) A total of 40 hours per month in the following areas: Physical therapy, speech therapy and occupational therapy and psychiatric or psychological services.

(B) Two hours per month of nutritional services provided by a dietitian.

(2) Centers with an average daily attendance of 11-20 shall provide at a minimum:

(A) A total of 80 hours per month in the following areas: Physical therapy, speech therapy, occupational therapy and psychiatric or psychological services.

(B) Four hours per month of nutritional services provided by a dietitian.

(3) Centers with an average daily attendance of 21-30 shall provide at least:

(A) A total of 120 hours per month in the following areas: Physical therapy, speech therapy, occupational therapy and psychiatric or psychological services.

(B) Six hours per month of nutritional services provided by a dietitian.

(4) Centers with an average daily attendance of 31-40 shall provide at least:

(A) A total of 160 hours per month in the following areas: Physical therapy, speech therapy, occupational therapy and psychiatric or psychological services.

(B) Seven hours per month of nutritional services provided by a dietitian.

(5) Centers with an average daily attendance of 41-50 shall provide at least:

(A) A total of 200 hours per month in the following areas: Physical therapy, speech therapy, occupational therapy and psychiatric or psychological services.

(B) Eight hours per month of nutritional services provided by a dietitian.

(6) Centers with an average daily attendance of 51-60 shall provide at least:

(A) A total of 240 hours per month in the following areas: Physical therapy, speech therapy, occupational therapy and psychiatric or psychological services.

(B) Ten hours per month of nutritional services provided by a dietitian.

(7) An additional half-time licensed vocational nurse shall be provided for each increment of 10 in average daily attendance exceeding 40.

(8) An additional half-time social work assistant shall be provided for each increment of 10 in average daily attendance exceeding 40.

(9) Program aides shall be provided in a ratio of one-half aide for every increment of eight in average daily attendance.

(10) The program director of centers whose average daily attendance is 20 or less may also serve as the registered nurse, social worker, occupational therapist, physical therapist, speech therapist or dietitian, provided that:

(A) The program director meets the professional qualifications for that position.

(B) The program director and the administrator are not the same person.

(11) The center may request staffing variations to these staffing requirements according to Section 78217, Title 22, California Administrative Code.

(b) Adult day health centers which serve participants whose primary language is other than English, shall employ sufficient trained staff to communicate with and facilitate rendering services to such participants. When a substantial number of the participants are in a non-English speaking group, bilingual staff shall be provided. Bilingual staff shall be persons capable of communicating in English and the preferred language of the participant.

54425. Participant Records.

(a) Each center shall maintain a complete health record for each participant in the program in the format established by the Department. Each medical record shall include, but is not limited to:

(1) Identifying information including:

(A) Name, address, telephone number, sex, age, ethnic background, Social Security and Medi-Cal numbers.

(B) Name, address and phone number of responsible person.

(2) Admission data including:

(A) Referral source.

(B) Reason for application as given by referral source, participant and family or others.

(C) Date of entry into the program, number of days scheduled for attendance, method of transportation and fee if non-Medi-Cal.

(3) Signed Agreement of Participation.

(4) Daily records of participant's attendance and services utilized, including transportation.

(5) Records shall be maintained of:

(A) Referrals to other providers.

(B) Dates and substance of communications with the participants' physician, family members and other persons providing assistance.

(6) Medication records.

(7) Medication errors and drug reactions shall be recorded with notation of action taken.

(8) Progress notes by involved personnel.

(9) Assessment of the participants by the multidisciplinary team .

(10) Physician examination and medical history.

(11) Individual plan of care.

54429. Solicitation.

(a) Adult day health centers shall not:
(1) Hire persons solely for the purpose of solicitation of participants.

(2) Offer money or any valuable consideration as an inducement to become a participant.

(3) Make false statements in advertising in any media.

(4) Make false statements to prospective participants regarding any aspect of the program.

(b) Adult day health centers may assign employed staff to meet with community organizations to provide information concerning the program.

54431. Service Area.

(a) Each adult day health center shall serve only participants living in the service area specified in the county plan and approved by the Department. An exception to this requirement may be granted only if the center meets a special need of a particular individual residing outside the service area. Special needs shall be limited to:
(1) The individual does not reside in an adult day health service area.

(2) The adult day health care center in the individual's service area does not provide a needed service.

(3) The individual is a former resident of the service area.

(4) The center offers strong ties to the cultural background of the individual which are not available in the area in which the individual resides.

(b) The following procedures shall be followed in obtaining a waiver:

(1) The center shall send a written waiver request to the Department. A personal letter from the individual stating the reasons for the request shall be attached.

(2) The center shall request a written statement from the participant's personal physician explaining why the lack of service area waiver would be detrimental to the person's total health needs.

(c) The Department shall not provide reimbursement for transportation provided outside the service area.

54433. Subcontracts.

(a) All subcontracts shall be in writing.

(b) Each subcontract shall be submitted to the Department at least 60 days prior to the effective date. If the Department does not formally act on a subcontract within 60 days after receipt, the adult day health care provider may use the services of the subcontractor.

(c) Each subcontract shall include at least the following:

(1) Full disclosure of the amount of compensation or other consideration to be received by the subcontractor from the adult day health center. That requirement provision shall not apply to subcontracts with providers employed or salaried by the adult day health care provider.

(2) Specification of the services to be provided and the times and days when these services are available to members.

(3) A provision that the subcontract shall be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the adult day health care provider.

(4) A provision that the Department and the Department of Health, Education and Welfare shall have the right to inspect or reproduce all books and records of the subcontractor as they relate to the provision of goods and services under the terms of the subcontract. Such books and records shall be available for inspection or reproduction at all reasonable times at the subcontractor's place of business for a term of at least four years from the effective date of the subcontract.

(5) A provision requiring the subcontractor, upon written request, to furnish financial reports relating to the provision of services under the subcontract and the payment therefore to the adult day health center and to the Department in such form and at such times as required by the adult day health care provider to fulfill its obligations for financial reporting to the Department.

54435. Civil Rights of Participants.

(a) The adult health center shall not discriminate against participants because of race, color, creed, national origin, sex, physical or mental handicaps in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d, rules and regulations on the grounds of race, color, creed, national origin or physical or mental handicaps include, but are not limited to, the following:

(1) Denying a participant any service or benefit or availability of a facility.

(2) Providing any service or benefit to a participant which is different or is provided in a different manner or at a different time from that provided to other participants.

(3) Restricting a participant in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit.

(4) Treating a participant differently from others in satisfying any admission, enrollment quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service or benefits.

(5) Assignment of times or places for the provision of services on the basis of the race, color, creed or national origin of the participants to be served.

(b) The adult day health care center will take affirmative action to ensure that participants are provided services without regard to race, color, creed, sex, national origin, physical or mental handicap.

(c) The center shall refer complaints alleging discrimination against the participants race, color, national origin, creed, sex, physical or mental handicap to the Department for review and appropriate action.

54437. Civil Rights of Employees.

(a) The center will not discriminate against any employee or applicant for employment because of race, color, creed, sex, national origin or mental or physical handicaps. The center will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, color, creed, sex, national origin, or mental or physical handicaps. Such action shall apply to all forms of personnel actions.

(b) The center shall, in all solicitations or advertisements for employees placed by or on behalf of the adult day health care provider, state that all qualified applicants will receive consideration for employment without regard to race, color, creed, sex, national origin, or mental or physical handicaps.

(c) The adult day health care provider shall send a notice provided by the Department to each labor union or representative of workers, with which it has a collective bargaining agreement or other contract or understanding, advising the labor union or workers' representative of the provider's equal opportunity commitments. Copies of the notice shall be posted in conspicuous places available to employees and applicants for employment.

54439. Confidentiality of Data.

(a) Names of persons receiving public social services are confidential as provided in Section 10850, California Welfare and Institutions Code, and are to be protected from unauthorized disclosure. Release of any information pertaining to adult day health care participants shall be made in accordance with the provisions of Section 51009, Title 22, California Administrative Code.

(b) All information, records, data and data elements collected and maintained for the operation of an adult day health center and pertaining to participants shall be protected by the adult day health care provider from unauthorized disclosure.

54443. Informational Material.

(a) Informational material provided to potential participants must have prior approval of the Department and must include the following:

(1) The name, address and phone number of the center.

(2) The service area boundaries.

(3) Eligibility criteria.

(4) A description of services provided at the center.

(5) The days and hours of operation.

(6) The cost per day.

(b) Information released to the media and the general public which contains eligibility or program information must have prior approval of the Department.

54445. Conflict of Interest.

(a) No state officer or state employee shall have a direct financial interest in a center or a direct financial interest in any contract with the adult day health care provider.

(b) No state officer or state employee shall provide legal or management services to the adult day health care provider, outside of specific duties as a state officer or state employee. No state officer or state employee shall share in the income or any remuneration derived from providing legal or management services to an adult day health care provider.

(c) No state officer or state employee shall receive anything of value for the purpose of influencing or attempting to influence the negotiations for approval or renewal of the provider agreement with the Department.

54447. Provider Sanctions.

(a) The Department shall, after warning, impose one or more of the following sanctions on adult day health care providers for violating time requirements as specified in Sections 54217 (d), 54403 (a), 54411, 54413 and 54507.

(1) Suspension of admission privileges.

(2) Forfeiture of all or part of the Medi-Cal reimbursement for each day the required documents are late.

54501. Adult Day Health Care Services.

(a) Department reimbursement for adult day health care services shall be the usual charges made to the general public by the center not to exceed the maximum reimbursement rates listed in this section.

(b) The maximum all-inclusive rate per day of attendance for each approved Medi-Cal participant shall be $68.57.

(c) Payments shall be made only for days of attendance in the time period approved by the Medi-Cal consultant.

(d) The comprehensive daily rate shall be reduced by the Department for any component of the required basic services which is funded in part or in whole from any other source, as indicated in fiscal reports submitted in accordance with Section 54413 or as determined by a Department fiscal audit. Failure to report other income sources may, at the discretion of the Department, result in suspension of certification.

(e) The comprehensive daily rate shall be payment in full for all adult day health care services provided to the Medi-Cal participant. Physical therapy, occupational therapy and speech therapy provided or arranged by the center beyond the requirements stated in Section 54423 (a) may be reimbursed according to Sections 51507, 51507.1 and 51507.2 if a separate prior authorization request is approved for physical therapy in accordance with Section 51309 (b) or for rehabilitation center outpatient services in accordance with Section 51314. A written statement, signed by the adult day health care provider, certifying that they are meeting the requirements of Section 54423 (a) for the time period of the treatment authorization request and that the therapeutic needs of this participant are in excess of Section 54423 requirements, shall be attached to the claim and prior authorization request.

(f) A provider of adult day health care shall not submit claims to or demands or otherwise collect reimbursement from a Medi-Cal participant, or from other persons on behalf of the participant, for any service included in the daily rate for adult day health care services unless the exceptions of Section 51002, Division 3, Chapter 3, Title 22, California Administrative Code, apply.

(g) The daily rate includes costs for purchase of meals and transportation. Utilization of existing community resources for meals and transportation is mandated unless the adult day health care provider can justify to the satisfaction of the Department the need to provide meals or transportation directly.

(h) The maximum number of payments for days of attendance for any 24-hour period shall not exceed the licensed capacity.

(i) A provider of adult day health care shall make reasonable efforts to recover the value of services rendered to participants whenever said participants are covered for the same services, either fully or partially, under any other state or federal program or under other contractual or legal entitlement, including but not limited to, a private group or indemnification program. Such recoveries are returned to the Department. A provider shall notify the Department if efforts to recover payment are unsuccessful.

(j) A provider of adult day health care shall not attempt to recover the value of services rendered when such recovery shall result from an action involving third-party tort liability. The provider shall notify the Department of any situation in which it appears that a participant will benefit from a third-party liability.

54503. Fee Schedule.

Each approved adult day health care provider shall establish a fee schedule for services to the general public.

54504. Transition Visits.

(a) An adult day health care provider may be reimbursed for a maximum of five transition visits per institutionalized participant, each visit consisting of two to four hours at the adult day health center. Transition visits to an adult day health care center may be made by an inpatient of:

(1) An acute hospital utilizing administrative days,

(2) An Intermediate Care Facility, or

(3) A Skilled Nursing Facility.

(b) Reimbursement for the transition visits shall not exceed 85% of the center's current approved daily rate.

(c) The attending physician shall authorize the transition visits. Physician approval shall be documented in the patient's chart.

54505. Initial Assessment Rate.

(a) An approved adult day health care provider shall be reimbursed for one initial assessment by the provider's multidisciplinary team for each new participant. Assessment made after a discharge and for reentry is not reimbursable for a reentry less than 12 months after the discharge of the same participant.

(b) Reimbursement for the initial assessment shall be based on the center's current approved daily rate plus five percent.

(c) Reimbursement for the initial assessment shall be limited to a maximum of three days.

54507. Billing Requirements.

(a) All charges submitted for payment shall be on billing forms approved by the Department. The billing shall include a monthly invoice, the number of days of attendance for each participant and monthly service reports.

(b) Billing shall be submitted by the adult day health care provider directly to the Department for the month of service. Billings are due by the 15th of the month following the month of service.

(c) Billing for initial assessments days shall be submitted on the invoice and shall meet the requirements of (a) and (b).

55000. General.

(a) The United States Congress has declared that it is the policy of the United States, in fulfillment of the special responsibilities and legal obligations to the American Indian people, to meet the national goal of providing the highest possible health status to Indians. In furtherance of these national goals and national policy, special programs have been developed by the Federal Government to address the health problems of Indians living on and near the Indian reservations, in rural areas, and in urban centers.

(b) These regulations are intended to recognize the inherent sovereignty of Indian tribes and nations, the requirements of the Indian Health Care Improvement Act and the Indian Self-Determination and Education Assistance Act, and to recognize the special status of Indians, Indian tribes, and Indian Health Service programs under federal law. This special status requires that separate considerations be applied to the inclusion or exclusion of Indians and Indian Health Service Facilities from Medi-Cal managed care plans.

(c) The programs operated by Indian tribes and Indian organizations within California, referred to in these regulations as Indian Health Service Facilities, are required by federal law to provide services to all eligible Indians who present themselves for care. Indian Health Service Facilities are also required by federal law to act as the payor of last resort for eligible Indians and are required to obtain reimbursement for the services provided to eligible Indians from all sources including the Medi-Cal program. These facilities may serve non-Indians, but only to the extent that such services do not result in the denial or diminution of health services to eligible Indians.

(d) The department intends to provide a single, clear, and accessible set of guidelines which define how Indian Health Service Facilities will relate to the Medi-Cal managed care plans in their respective locations; to ensure that individual Indians continue to receive the required care to which they are entitled; and to ensure that Indian Health Service Facilities may continue to provide comprehensive services to eligible Indians.

(e) The department intends to ensure that the Indian Health Service Facilities are reimbursed, if they are qualified for and elect to receive reasonable cost reimbursement, as provided in federal law, at their reasonable cost reimbursement rate, or a percentage of reasonable cost as provided in 42 U.S.C. 1396a(a)(13)(C), whether they elect to act as subcontractors of the Medi-Cal managed care plans or out-of-plan providers.

(f) The department also intends to ensure that Indian Health Service Facilities which choose to be and are designated as Indian Health Service (IHS) providers by the federal government will receive the IHS payment rate.

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act as subcontractors of the Medi-Cal managed care plans or out-of-plan providers.

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55100. Definitions.

The following definitions shall control the construction of this chapter unless the context requires otherwise.
(a) County organized health system means a Medi-Cal managed care plan contracting with the department to serve enrolled beneficiaries under the authority of Welfare and Institutions Code, Section 14499.5, or Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.8, commencing with Section 14087.5.

(b) Disenrollment means the process under which a member's entitlement to receive services from a Medi-Cal managed care plan is terminated.

(c) Federally qualified health center means an entity which:
(1) Is receiving a grant under Section 330 of the Public Health Service Act;

(2) Is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under Section 330 of such Act;

(3) Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary of Health and Human Services to meet the requirements for receiving such a grant; or

(4) Was treated by the Secretary, for purposes of Part B of Title XVIII, as a comprehensive federally funded health center as January 1, 1990; and

(5) May be an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

(d) Fee-for-service managed care plan means a Medi-Cal managed care plan that does not assume financial risk for the provision of services to its members.

(e) Fee-for-service managed care program means a single fee-for-service managed care plan contracting in a county to provide or arrange for health care services to mandatorily enrolled Medi-Cal beneficiaries.

(f) Fee-for-service provider means a provider of services as defined in Section 51051 which has been issued a Medi-Cal provider number by the department.

(g) Geographic managed care program means a health care delivery system consisting of Medi-Cal managed care plans contracting with the department under the authority of Welfare and Institutions Code Sections 14089 or 14089.05 to provide services to mandatorily enrolled Medi-Cal beneficiaries.

(h) Health care options program means the program established by the department to inform Medi-Cal beneficiaries of their options for receiving Medi-Cal benefits in areas served by Medi-Cal managed care plans other than county organized health systems.

(i) Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c and 42 CFR Section 36.12) to receive health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.

(j) Indian Health Service Facility means a tribal or urban Indian organization operating health care programs or facilities with funds from the Department of Health and Human Services, Indian Health Service, appropriated pursuant to the Indian Health Care Improvement Act (25 U.S.C. Section 1601 et. seq.) or the Snyder Act (25 U.S.C. Section 13 et. seq.).

(k) Lock-in means the restriction of a member's right to disenroll from a Medi-Cal managed care plan without good cause.

(l) Medi-Cal managed care plan means an entity contracting with the department to provide health care services to enrolled Medi-Cal beneficiaries under Chapter 7, commencing with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3, of the Welfare and Institutions Code.

(m) Medi-Cal managed care program means a program established by the department in which participation requirements for beneficiaries and Medi-Cal managed care plans have been standardized. As used in this article, Medi-Cal managed care programs include the two-plan model, Geographic Managed Care, prepaid health plan, primary care case management, county organized health systems, and fee-for-service managed care programs.

(n) Member means any Medi-Cal beneficiary who has enrolled in a Medi-Cal managed care plan.

(o) Prepaid health plan program means the Medi-Cal managed care program in which beneficiaries may voluntarily enroll in Medi-Cal managed care

plans contracting with the department under Welfare and Institutions Code Section 14200 et seq.

(p) Primary care case management program means the Medi-Cal managed care program in which beneficiaries may voluntarily enroll in Medi-Cal managed care plans contracting with the department under Welfare and Institutions Code Section 14088 et seq.

(g) Two-plan model means the health care delivery system described in Section 53800, consisting of two Medi-Cal managed care plans in a county providing services to mandatorily enrolled Medi-Cal beneficiaries.

55110. Enrollment of Indians in Medi-Cal Managed Care Plans.

(a) Indians shall not be required to enroll in any Medi-Cal managed care plans, with the exception of county organized health systems.

(b) Indians who are enrolled in a Medi-Cal managed care plan, including county organized health systems, shall not be restricted in their access to Indian Health Service Facilities by the Medi-Cal managed care plan.

(c) Notwithstanding any other regulations in this title, Indians who are enrolled in a Medi-Cal managed care plan other than a county organized health system shall be permitted to disenroll from the Medi-Cal managed care plan without cause as of the beginning of the first calendar month following a full calendar month after the request for disenrollment is made. Indians shall not be subject to any lock-in provisions which may apply to other members of Medi-Cal managed care plans.

55120. Indian Health Service Facility Participation in Medi-Cal Managed Care Programs.

(a) Indian Health Service Facilities may participate in the Medi-Cal managed care program as a subcontractor with a Medi-Cal managed care plan, if agreement is reached between the parties to the subcontract and the subcontract is approved by the department. Approval by the department shall be based on the subcontract's compliance with standards applicable to all subcontracts held by Medi-Cal managed care plans, including standards relative to appropriate reimbursement rates.

(b) In the two-plan model, the department shall require the local initiative to offer a subcontract to each Indian Health Service Facility located in the designated region served by the local initiative under the two-plan model. If there is no local initiative in a county and the department exercises its option under Section 53800(b)(3), the department shall establish participation standards for Indian Health Service Facilities that provide that at least one of the two Medi-Cal managed care plans participating in the program shall

offer a subcontract to each Indian Health Facility located in the designated region served by the plans under the two-plan model. The terms of these subcontracts shall be consistent with the requirements of this chapter and, in other respects, shall be consistent with the terms and conditions offered to other subcontractors providing a similar scope of services.

(c) In counties with mandatory enrollment in Medi-Cal managed care programs other than the two-plan model and county organized health systems, the department shall establish participation standards for Indian Health Service Facilities. These standards shall provide that at least one Medi-Cal managed care plan participating in the program in the county shall offer a subcontract to each Indian Health Facility located in the geographic region served by the program. The terms of these subcontracts shall be consistent with the requirements of this chapter and, in other respects, shall be consistent with the terms and conditions offered to other subcontractors providing a similar scope of services.

(d) In the two-plan model program or in a Geographic Managed Care program, if the Indian Health Service Facility does not participate as a subcontractor, the department shall accept applications to the extent permitted by federal law from an Indian Health Service Facility interested in contracting as a fee-for-service managed care plan under Section 55130. The fee-for-service managed care plan may only enroll Indians and the number of non-Indians receiving services from the Indian Health Service Facility at the time of application to the department. If departmental resources limit the implementation and monitoring of additional fee-for-service managed care plans, the department may discontinue the acceptance of applications and implemention of any additional fee-for-service managed care programs by providing six months written notice of its intent to discontinue acceptance and implementation to the California Area Office, Indian Health Service, Public Health Service, Department of Health and Human Services.

55130. Indian Health Service Facilities as Fee-for-Service Managed Care Plans.

(a) If, under the option provided in Section 55120(d), the Indian Health Service Facility elects to become a fee-for-service managed care plan, the Indian Health Service Facility shall act as primary care case manager for Medi-Cal beneficiaries who are Indians or non-Indians currently receiving services from the Indian Health Service Facility, once they voluntarily enroll with the Indian Health Service Facility fee-for-service managed care plan. The plan shall be responsible to provide or arrange for health care services for its members as agreed to in the contract between the department and the Indian Health Service Facility. The department shall inform Medi-Cal beneficiaries who are Indians or non-Indians currently receiving services from the Indian Health Service Facility of their option to enroll in the Indian Health Service Facility fee-for-service managed care plan through the health care options program.

(b) To participate as a fee-for-service managed care plan, the Indian Health Service Facility must demonstrate sufficient resources and capability to implement the fee-for-service managed care contract, including, but not limited to:

(1) Medical and administrative staff.

(2) Information systems.

(3) Organizational structure.

(4) Financial solvency.

(5) Quality improvement system.

(6) Member grievance system.

55140. Indian Health Service Facility Reimbursement When Subcontracting with a Medi-Cal Managed Care Plan.

(a) A Medi-Cal managed care plan subcontracting with an Indian Health Service Facility shall reimburse the Indian Health Service Facility for services according to one of the following reimbursement options:

(1) If the Indian Health Service Facility is a rural health clinic or qualifies as a federally qualified health center, the Medi-Cal managed care plan shall reimburse the facility at the facility's interim per visit rate as established by the department, or through an alternate reimbursement methodology approved in writing by the department.

(2) If the Indian Health Service Facility is a rural health clinic or a federally qualified health center and the facility and the Medi-Cal managed care plan have agreed to an at-risk rate and the Indian Health Service Facility has waived its right to cost-based reimbursement under the subcontract, the Medi-Cal managed care plan shall reimburse the facility at the negotiated rate.

(3) If, prior to the effective date of these regulations, a Medi-Cal a managed care plan has negotiated a subcontract, which has been approved by the department, with an Indian Health Service Facility that is a federally qualified health center or a rural health clinic, and this subcontract contains terms for reimbursement other than cost-based reimbursement as described in subsection (c), the Medi-Cal managed care plan may continue to reimburse the facility at the agreed rate under the subcontract.

(4) If the Indian Health Service Facility is entitled to be reimbursed as an Indian Health Service provider by the federal government at a reimbursement rate other than the rate described in subsection (a)(1), the Medi-Cal managed care plan shall reimburse the facility at the Indian Health Service payment rate.

(b) Referrals made by the Indian Health Service Facility to other providers shall be in accordance with the terms of the subcontract.

(c) If the Indian Health Service Facility has elected to subcontract with a Medi-Cal managed care plan and qualifies to be reimbursed as a rural health clinic or federally qualified health center on the basis of reasonable cost, as provided in federal law, the department shall reimburse or recover from the Indian Health Service Facility at least annually an amount equalling the difference between payments received from the Medi-Cal managed care plan through the subcontract and reasonable cost reimbursement, or a percentage of reasonable cost as provided in 42 U.S.C. 1396a(a)(13)(C), as a part of the department's annual reconciliation process with the facility for all Medi-Cal services. As a condition of obtaining the reconciliation, the Indian Health Service Facility shall maintain a record of the number of visits by plan members separate from visits by fee-for-service Medi-Cal beneficiaries.

55150. Indian Health Service Facility Out-of-Plan Reimbursement.

When the Indian Health Service Facility provides services covered by a Medi-Cal managed care plan to members of that plan and the Indian Health Service Facility does not have a subcontract with the Medi-Cal managed care plan or has a subcontract but is providing services to members not covered by the subcontract, the following reimbursement requirements shall apply:
(a) For Medi-Cal beneficiaries who are Indians, the Medi-Cal managed care plan shall reimburse the Indian Health Service Facility for services provided to the beneficiary at the applicable reimbursement rate that would have been received by the Indian Health Service Facility if the service has been rendered to a Medi-Cal beneficiary through the Medi-Cal fee-for-service program.

(b) For Medi-Cal beneficiaries who are not Indians, the Medi-Cal managed care plan shall reimburse the Indian Health Service Facility only if the Medi-Cal managed care plan has authorized the service or if the Medi-Cal managed care plan is obligated by its contract with the department to pay out-of-plan providers for the service without prior authorization (e.g., emergency services or family planning services). If reimbursement is required, reimbursement shall be at the applicable reimbursement rate that would have been received by the Indian Health Service Facility if the service had been rendered to a Medi-Cal beneficiary through the Medi-Cal fee-for-service program.

(c) The Indian Health Service Facility may be required, as a condition of payment, by the Medi-Cal managed care plan to submit supporting

documentation or specific claim information in a format acceptable to the Medi-Cal managed care plan, pursuant to the Medi-Cal managed care plan's out-of-plan claims procedures which are required by the Medi-Cal managed care plan of any other provider of out-of-plan services. In addition, a Medi-Cal managed care plan may request from the Indian Health Service Facility, as a condition of payment, verification of a person's eligibility as an Indian, as defined in section 55100.

(d) Referrals made by the Indian Health Service Facility to other providers shall be coordinated with the Medi-Cal managed care plan. Providers which accept the referrals shall be responsible for obtaining authorization and payment from the Medi-Cal managed care plan.

55160. Indian Health Service Facility Fee-for-Service Managed Care Plan Reimbursement.

If the Indian Health Service Facility provides services as a fee-for-service managed care plan, the department shall reimburse the facility at the applicable reimbursement rate that would have been received by the Indian Health Service Facility if the service had been rendered to a Medi-Cal beneficiary through the Medi-Cal fee-for-service program for each qualifying visit by a member of the fee-for-service managed care plan. In addition, the department shall pay a monthly case management fee established by the department for each member. If the Indian Health Service Facility qualifies for reasonable cost reimbursement, as provided in federal law, the department shall reimburse or recover from the Indian Health Service Facility at least annually an amount equalling the difference between the payments received from the department, excluding case management fees, and reasonable cost reimbursement, or a percentage of reasonable cost, as provided in 42 U.S.C. 1396a(a)(13)(C).

55170. Indian Health Service Facilities and Non-Indian Beneficiaries.

The Indian Health Service Facility will determine the number of non-Indian Medi-Cal beneficiaries which the facility will accept as patients with the following limitations:
(a) The facility must ensure that it maintains its historical and cultural character as an Indian Health Service Facility;

(b) The facility must ensure that it provides care to Indian patients at a satisfactory level, as required by federal law;

(c) If the Indian Health Service Facility subcontracts with a Medi-Cal managed care plan, the number of non-Indian members may be negotiated between the parties.

(d) In the two-plan model or a Geographic Managed Care program, if the Indian Health Service Facility elects to participate as a fee-for-service managed care plan, the Indian Health Service Facility shall enroll only Indians and the number of non-Indians receiving services from the Indian Health Service Facility at the time of its application to the department.

55180. Indian Health Service Facilities and the Health Care Options Program.

(a) In geographic areas served by a Geographic Managed Care program, the two-plan model, or where the health care options program is operating, Indian Health Service Facilities shall be listed as an option in the presentation and informing materials used to advise beneficiaries of their options for receiving Medi-Cal benefits. Indians and non-Indians currently receiving services from an Indian Health Service Facility in such an area may, as an alternative to enrollment in a Medi-Cal managed care plan, and upon request, choose to receive health care services through the Indian Health Service Facility. Such a request shall be made to the health care options program.

(b) In areas covered by subsection (a), if the Indian Health Service Facility provides the department with current information on Indian Medi-Cal beneficiaries and non-Indian Medi-Cal beneficiaries who are currently receiving services from the facility in the form agreed to between the department and the Indian Health Service Facility, the following shall apply:

(1) If an Indian Medi-Cal beneficiary, who is identified by the Indian Health Service Facility as currently receiving services from the facility, does not make a choice of options, that beneficiary shall not be assigned to a Medi-Cal managed care plan, but shall remain in the fee-for-service Medi-Cal program to allow the beneficiary to continue to receive care from the Indian Health Service Facility. This requirement shall apply whether or not the Indian Health Service Facility has subcontracted with a Medi-Cal managed care plan, but shall not apply if the Indian Health Service Facility is a fee-for-service managed care plan.

(2) Non-Indian Medi-Cal beneficiaries may be identified by the Indian Health Service Facility as currently receiving services from the facility. Such beneficiaries who do not make a choice of options shall not be assigned to a Medi-Cal managed care plan, but shall remain in the fee-for-service Medi-Cal program to allow those beneficiaries to continue to receive care from the Indian Health Service Facility. This requirement shall apply whether or not the Indian Health Service Facility has subcontracted with a Medi-Cal managed care plan, but shall not apply if the Indian Health Service Facility is a fee-for-service managed care plan.

(3) If the Indian Health Service Facility is a fee-for-service managed care plan, beneficiaries identified in subdivisions (1) and (2) who fail to make a choice shall be assigned to the Indian Health Service Facility's fee-for-service managed care plan.

56000. General.

(a) Health care services to eligible Medi-Cal beneficiaries may be provided through PCCM plans. PCCM plans shall:

(1) Contract with the Department to provide or arrange for the provision of the full scope of Medi-Cal services, unless certain services are specifically excluded under the terms of the contract, to Medi-Cal beneficiaries voluntarily electing to obtain health care services from the PCCM plan.

(2) Share in the risk of providing health care services.

(3) Provide readily available health care services and utilize preventive health care programs to improve the health status of their members.

(4) Case manage members' utilization of health care services.

(b) The definitions in Article 2 shall apply to Chapter 6 of this division unless the context requires otherwise.

56100. Acceptable Medical Care.

56101. Actuarial Equivalence.

Actuarial equivalence means the per capita costs for Medi-Cal fee-for-service beneficiaries adjusted by age, sex, aid category, geographic location, scope of services, and other appropriate factors in order to be comparable with the costs for Medi-Cal beneficiaries who are members of each PCCM plan.

56101.1. Actuarial Method.

Actuarial method means any reasonable and adequate method of determining prospective per capita rates of payment for PCCM plan members that is based on actual expenditures for fee-for-service Medi-Cal beneficiaries and recent comparable data from each PCCM plan and other prepaid populations. This data may include:
(a) Experience data to determine the expected costs of services and other requirements for which the rates will serve as payment.

(b) Experience data to determine the expected utilization of each service and other requirements for which the rates will serve as payment by the aid category, age and sex of the Medi-Cal members.

(c) Projected inflation in the costs of the services and other requirements during the period to be covered by the rates.

(d) Costs of any new services or requirements that will be required during the year for which the rates are determined but were not required during the previous year.

56102. Affiliate.

Affiliate means an organization or person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, a PCCM plan and that provides services to or receives services from a PCCM plan.

56114. Disenrollment.

Disenrollment means the process by which a member's entitlement to receive services from a PCCM plan is terminated.

56115. Door-to-Door Marketing.

Door-to-door marketing means the use of a marketing presentation at the residence of an individual who has not requested a presentation.

56115.5. Effective Date of Enrollment.

Effective date of enrollment means the first day of the first month in which a Medi-Cal beneficiary's name appears on the approved list of members furnished to the PCCM plan by the Department as a result of the completion of a designation form for enrollment in the PCCM plan.

56116. Enrollment.

Enrollment means the process by which a Medi-Cal beneficiary becomes a member of a PCCM plan.

56116.5. Experience Data.

Experience data means historical cost and utilization data from the Medi-Cal fee-for-service program, prepaid health plans, PCCM plans or other prepaid populations which is sufficient to enable accurate statistical analysis and comparison.

56117. Facility.

Facility means any location which is:
(a) Owned, leased, used or operated directly or indirectly by or for the benefit of a PCCM plan or its affiliates for purposes related to a PCCM contract, or

(b) Maintained by a provider for the provision of services on behalf of a PCCM plan.

56118. Marketing.

Marketing means:
(a) Any activity conducted by, or on behalf of, a PCCM plan in which information regarding the services offered is disseminated in order to persuade Medi-Cal beneficiaries to enroll, or accept a designation form for enrollment, in that PCCM plan, or

(b) Any presentation made by, or on behalf of, a PCCM plan to any individual or organization for the purpose of enrolling beneficiaries.

56120. Marketing Representative.

Marketing representative means any person engaged in marketing activities on behalf of a PCCM plan, pursuant to Article 4 of this Chapter.

56122. Member.

Member means any Medi-Cal beneficiary who has enrolled in a PCCM plan pursuant to section 56420.

56124. Optional Services.

Optional services means any Medi-Cal covered service included in the PCCM contract as a capitated service which the Department does not require the PCCM plan to provide under capitation.

56130. PCCM Contract.

PCCM contract means the written agreement entered into between a primary care provider as defined in section 14088 (b)(1), Welfare and Institutions Code and the Department, and approved by the Department of Finance to provide health care services to members under the provisions of sections 14088.16 and 14088.17, Welfare and Institutions Code.

56133. Risk Limit.

Risk limit means the per member dollar amount in excess of which the Department will reimburse the PCCM plan the cost, based on Medi-Cal fee-for-service rates, of capitated services rendered to any member.

56138. Service Site.

Service site means the location designated by a PCCM plan at which members shall receive health care services.

56144. Subcontract.

(a) Subcontract means an agreement between a PCCM plan and any of the following:

(1) A provider of health care services who agrees to furnish services to PCCM plan members.

(2) A marketing organization.

(3) Any other person or organization who agrees to perform any administrative function or service for the operation of the PCCM plan specifically related to securing or fulfilling its PCCM contractual obligations.

56144.5. Sub-Subcontract.

Sub-subcontract means any agreement, descending from and subordinate to a subcontract, which is entered into for the purpose of providing any goods or services connected with a PCCM plan's obligations under a PCCM contract.

56146. Written Approval.

56152. Vendor.

Vendor means any person who provides services or supplies to a PCCM plan or subcontractor of a PCCM plan and who does not have a written subcontract with the PCCM or its subcontractors.

56200. Organization and Administration.

Each PCCM plan shall have the organizational and administrative ability to carry out its contractual obligations.To demonstrate this ability, each PCCM plan shall maintain the following:
(a) A license to provide medical care.

(b) An approved Medi-Cal provider number.

(c) A grievance procedure as specified in section 56260.

(d) Member and enrollment reporting systems which fulfill the PCCM plan's contractual obligations.

(e) A data-reporting system which provides reports required under the contract to the Department on a timely basis.

(f) Financial records and books of account fully disclosing the disposition of all Medi-Cal program funds received under the PCCM contract. These records and books shall be maintained on the accrual basis and in a uniform accounting system in accordance with generally accepted accounting principles.

(g) A medical director as specified in section 56246.

56210. Scope of Services.

(a) Each PCCM plan shall provide or arrange for the provision of the full scope of Medi-Cal services set forth in Chapter 3, Article 4, beginning with section 51301, and in Chapter 11, beginning with section 59998, unless services are specifically excluded under the terms of the PCCM contract.

(b) A PCCM plan may elect to provide services which are not included in section 14053, Welfare and Institutions Code at no cost to members.

(c) A PCCM plan shall obtain the prior written approval of the Department if any services are to be provided at a cost to members. Departmental approval shall be based on compliance with State and federal law and regulation and the terms of the PCCM contract. Each member shall be notified of the scope of any non-Medi-Cal covered services offered by the PCCM plan and a full disclosure of any charges:
(1) Prior to the signing of any membership designation form.

(2) Any time the scope of services is changed, and

(3) Immediately prior to rendering services at a cost to members.

(d) Each PCCM plan shall meet the requirements of sections 51163 and 51305.1 through 51305.7 of this subdivision, in providing needed human reproductive sterilization services.

(e) Each PCCM plan shall provide Child Health and Disability Prevention Program Services to members under the age of 21 in accordance with the provisions of sections 6800 through 6874, Title 17, California Code of Regulations.

56212. Availability of Services.

56214. Pharmaceutical Services and Prescribed Drugs.

56216. Care Under Emergency Circumstances.

(a) Each PCCM plan shall provide information to members on obtaining medical services on a 24-hour-a-day, seven-days-a-week basis in the event of an emergency as defined in section 51056(a).

(b) Written procedures shall be developed and followed by the PCCM plan regarding care under emergency circumstances provided by nonplan providers in and outside the service area. These procedures shall include but shall not be limited to the following:

(1) Verification of membership.

(2) Transfer of medical management of the member to the PCCM plan.

(3) Payment for PCCM plan authorized services that are included in the PCCM contract as a covered service.

(4) Notice to nonplan providers of the right to:

(A) Dispute the PCCM plan's rejection or reduction of the claim.

(B) Submit the dispute to the Department for resolution in accordance with section 56262.

(c) When the course of treatment of a PCCM plan member under emergency services requires the use of drugs, the PCCM plan shall authorize the

provider to furnish a sufficient quantity of drugs to last until the member can reasonably be expected to have a prescription filled.

56220. Member Billing.

A PCCM plan, affiliate, vendor, subcontractor or sub-subcontractor shall not submit a claim to, demand, or otherwise collect reimbursement from, a member or persons acting on behalf of a member for any services provided under this chapter except to collect third-party payment in accordance with section 56222(a).

56222. Recovery from Other Sources.

(a) PCCM plans may recover and retain the cost of capitated services rendered to a member under the terms of this chapter, to the extent that the member is covered for these services under any other state or federal medical care program or under other contractual or legal entitlement, including but not limited to, a private group or individual indemnification program.

(b) PCCM plans shall not attempt recovery in circumstances involving casualty insurance, tort liability, or workers' compensation awards to PCCM plan members. Circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation awards shall be reported, in writing, to the Department within ten calendar days after discovery by the PCCM plan.

56230. Facilities and Service Sites.

(a) Each PCCM plan shall have available within the service area, sufficient facilities and service sites to meet its contractual obligations.

(b) Each facility shall meet the following requirements:

(1) Licensing, and accreditation where applicable, by appropriate agencies.

(2) Continued compliance with licensing standards.

(3) Compliance with all applicable local, state and federal standards including those for fire and safety.

(c) Each PCCM plan and subcontracting facility shall be subject to an onsite inspection by the Department prior to approval for use in providing services to members under the terms of the PCCM contract or

the subcontract. Inspections for continuing facility adequacy shall be conducted periodically thereafter.

56242. Providers.

A provider of services employed by or under subcontract to a PCCM plan shall meet those standards for participation as a provider of health care services under the Medi-Cal program set forth in Chapter 3, Article 3, beginning with section 51200.

56246. Medical Director.

Each PCCM plan shall appoint a physician as medical director. The medical director's responsibilities shall include, but not be limited to:
(a) Ensuring that medical decisions are rendered by qualified medical personnel.

(b) Ensuring that authorized physicians and medical personnel are trained on Treatment Authorization Requests, authorization requirements, and procedures for noncapitated services.

(c) Ensuring that the PCCM plan's medical standards are followed.

(d) Developing and implementing medical policy.

(e) Resolving medically related grievances. The medical director shall refer nonmedical grievances to the PCCM plan's grievance procedure pursuant to section 56260.

(f) Actively participating in the functioning of the PCCM plan grievance procedures.

56250. Subcontracts.

(a) A provider or management subcontract entered into by a PCCM plan shall become effective upon submission to and approval in writing by the Department. Departmental approval shall be based on compliance with (b) and (c) below.

(b) A PCCM plan that subcontracts for the provision of any health care service to PCCM plan members shall ensure that the subcontractor meets all requirements of Chapters 3 and 6 related to services a PCCM plan is required to perform.

(c) Each subcontract submitted for Department approval pursuant to subdivision (a), shall contain at least the following:
(1) Specification of the services to be provided.

(2) Specification that the subcontract shall be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the PCCM plan.

(3) Specification that the subcontract or subcontract amendments shall become effective only as set forth in subdivision (a).

(4) Specification of the term of the subcontract, including the beginning and ending dates, as well as methods of extension, renegotiation and termination.

(5) Subcontractor's agreement to submit reports as required by the PCCM plan and the Department.

(6) The subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination or copying:

(A) By the Department and by the Department of Health and Human Services.

(B) At all reasonable times at the subcontractor's place of business, or at some other mutually agreeable location in California.

(C) In a form maintained in accordance with the general standards applicable to book or record keeping.

(D) For the term required by section 56310.

(7) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the PCCM plan.

(8) Subcontractor's agreement to maintain and make available to the Department, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the sub-subcontractor:

(A) Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Department and by the Department of Health and Human Services.

(B) Retain all books and records pertaining to its PCCM sub-subcontract in accordance with section 56310.

(9) Subcontractor's agreement to notify the Department in the event the agreement with the PCCM plan is amended or terminated. Notice to the Department is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

(10) Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from the Department.

(11) Subcontractor's agreement to hold harmless both the State and PCCM plan members in the event the PCCM plan cannot or will not pay for services performed by the subcontractor pursuant to the subcontract.

56251. Assumption of Financial Risk.

(a) PCCM plans shall be responsible for the total costs, except as otherwise provided in this chapter, of services covered at risk rendered to members under PCCM contracts.

(b) If so agreed by contract, the Department shall bear the costs of providing medically necessary covered services to a member when costs, based on Medi-Cal schedules of reimbursement and exclusive of third-party recoveries, exceed the risk limit in the aggregate during the 12-month period specified in the contract. The risk limit shall be determined annually, at the same time and using the same data base as used in the determination of new annual rates pursuant to section 56321, and shall be stated in the contract. The Department shall bear costs only for the period of time between the date on which the aggregate amount exceeds the risk limit, and the end of the 12-month period specified in the contract. Within 90 calendar days after submittal of the documentation required in subdivision (b)(2), the Department shall determine whether services are medically necessary and the amounts payable under the schedule of Medi-Cal benefits are reasonable prior to payment.

(1) Members whose cost of care exceeds the risk limit in the 12-month period shall not be disenrolled by the PCCM plan solely for that reason. The PCCM plan shall continue to provide case management and any other services specified by its PCCM contract with the Department.

(2) PCCM plans shall submit to the Department documentation of accumulated costs which result in reaching the risk limit and of all costs in excess of the limit.

(c) A PCCM plan shall not enter into any subcontract which would remove the PCCM plan's obligation to bear a significant portion of the overall risk assumed in providing capitated services under this Chapter.

(d) Significant portion of risk shall be the financial responsibility for all expenditures which exceed 115 percent of the specific total expenditures made under each subcontract in excess of the amount paid to the subcontractor by the PCCM plan in any contract year.

56252. Reinsurance.

(a) The provisions of section 56251 notwithstanding, the PCCM plan may obtain reinsurance for the cost of providing capitated services, subject to the following conditions:

(1) Reinsurance shall not reduce the PCCM plan's liability below the minimum liability per member for any one12-month period, as set forth in the PCCM contract.

(2) Reinsurance may cover both of the following:

(A) The total cost of capitated services provided to members under emergency circumstances by nonplan providers.

(B) Up to 90 percent of all expenditures related to the contract exceeding 115 percent of the PCCM plan's gross income from capitation payments and third-party recoveries under the terms of the contract during any PCCM plan fiscal year.

56260. Grievance Procedures.

Each PCCM plan shall establish and maintain a procedure for submittal, processing and resolution of all member and provider grievances and complaints.

56261. Notice to Members of PCCM Plan Action to Deny, Defer or Modify a Request for Medical Services.

(a) The PCCM plan shall provide members with a notice of an action taken by the PCCM plan to deny a request by a provider for any medical service. Notice in response to an initial request from a provider shall be provided in accordance with this section. Notice in response to a request for continuation of a medical service shall be provided in

accordance with section 51014.1. Notice of denial shall not be required in the following situations:

(1) The denial is a denial of a request for prior authorization for coverage for treatment that has already been provided to the member.

(2) The denial is a non-binding verbal description to a provider of the services which may be approved by the PCCM plan.

(3) The denial is a denial of a request for drugs, and a drug identical in chemical composition, dosage, and bioequivalence may be obtained through prior authorization from the PCCM plan or from the list, established by the PCCM plan, of drugs available without prior authorization from the plan.

(b) The PCCM plan shall provide members with a notice of deferral of a request by a provider for a medical service. Notice of the deferral shall be delayed for 30 days to allow the provider of the medical services time to submit the additional information requested by the plan and to allow time for the PCCM plan to make a decision. If, after 30 days from the PCCM plan's receipt of the request for prior authorization, the provider has not complied with the PCCM plan's request for additional information, the PCCM plan shall provide the member notice of denial pursuant to subdivision (a). If, within that 30 day period, the provider does comply, the PCCM plan shall take appropriate action on the request for prior authorization as supplemented by the additional information, including providing any notice to the member.

(c) The PCCM plan shall provide members notice of modification of a request by a provider for prior authorization. Notice in response to an initial request from a provider shall be provided in accordance with this subdivision. Notice in response to a request for continuation of a medical service shall be provided in accordance with section 51014.1. Notice of modification pursuant to this subdivision shall not be required in the following situations:

(1) The PCCM plan may modify a request for durable equipment without notice, as long as the substituted equipment is capable of performing all medically significant functions that would have been performed by the requested equipment.

(2) The PCCM plan may modify the duration of any approved therapy or the length of stay in an acute hospital inpatient facility without notice as long as the PCCM plan provides an opportunity for the provider to request additional therapy or inpatient days before the end of the approved duration of the therapy or length of stay.

(d) The written notice of action issued pursuant to subdivision (a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:

(1) The action taken by the PCCM plan.

(2) The reason for the action taken.

(3) A citation of the specific regulations or PCCM plan authorization procedures supporting the action.

(4) The member's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the member may be either:

1. Self represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) The time limit for requesting fair hearing.

(e) For the purposes of this section, medical services means those services that are subject to prior authorization under the PCCM plan's authorization procedures.

(f) The provisions of this section apply only for medical services that are covered in the contract between the Department and the PCCM plan.

(g) The provisions of this section do not apply to the decisions of providers serving plan members when prior authorization of the service by the PCCM plan's authorization procedures is not a condition of payment to the provider for the medical service.

56262. Provider Grievance and Complaints.

(a) A provider of medical services may submit a grievance or complaint concerning the authorization or denial of a service or the processing, payment or nonpayment of a claim by a PCCM plan as follows:

(1) The provider shall initiate a first level appeal, by submitting a grievance or complaint in writing, within 30 calendar days of the action precipitating the grievance or complaint, to the PCCM plan identifying the claim involved and specifically describing the disputed action or inaction regarding the claim.

(2) The PCCM plan shall acknowledge the written grievance or complaint within 15 calendar days of its receipt.

(3) The PCCM plan may refer a grievance or complaint to professional peer review.

(A) When the grievance or complaint is not referred to professional peer review, the PCCM plan shall review the merits of the grievance or complaint and send a written report of its conclusion and reasons to the provider within 30 calendar days of the acknowledgement of the receipt of the grievance or complaint.

(B) When the grievance or complaint is referred to professional peer review:

1. All parties concerned shall be notified that a referral has been made to professional peer review and that a final determination may require up to 60 calendar days from the acknowledgement of the receipt of the grievance or complaint.

2. The professional peer review shall make its evaluation and submit its findings and recommendations to the PCCM plan and the provider within 30 calendar days after the receipt of the referral from the PCCM plan.

3. The PCCM plan, after taking into consideration the findings and recommendations of the professional peer review, shall send a written report of its conclusions and reasons to the provider within 30 calendar days of receipt of the recommendation.

4. The PCCM plan shall retain all documentation related to the peer review in accordance with section 56310.

(b) A provider may, after complying with subdivision (a) above, refer the grievance or complaint to the Department for a second level of appeal:

(1) Within 30 calendar days of receipt of the PCCM plan's written report of its conclusion, or

(2) When the PCCM plan has failed to act within the deadlines set forth in subdivision (a).

(c) In a second level appeal for a grievance or complaint to the Department, the provider shall submit the following to the Department:

(1) A letter requesting the Department to review the first level of appeal.

(2) A copy of the letter sent to the PCCM plan requesting the first level of appeal.

(3) A copy of the original documents submitted to the PCCM plan.

(4) A copy of the first level appeal denial response letter if the second level of appeal is based on denial.

(5) A copy of any other correspondence between the PCCM plan and the provider that documents timely submission and the validity of the appeal.

(d) The Department shall acknowledge the second level appeal request by a provider within 15 calendar days of its receipt, and shall send written notice to the PCCM plan of the appeal.

(e) The Department shall review the written documents submitted in the provider's appeal, may ask for additional information, and may hold an informal meeting with the involved parties. The Department shall send a written report of its conclusions and reasons to the provider and the PCCM plan within 60 calendar days of receipt of the appeal from the provider.

56264. Member Complaints.

56280. Quality of Care.

56284. Confidentiality of Medical Records.

Each PCCM plan shall maintain confidentiality of medical records in accordance with the provisions of section 51009 and with section 14100.2, Welfare and Institutions Code.

56286. Continuity of Care.

(a) Each PCCM plan shall designate a primary care physician to supervise and coordinate each member's health care. Any member dissatisfied with the primary care physician shall be allowed to select another if more than one is available. Any PCCM plan physician dissatisfied with the professional relationship with any PCCM plan member may request that another primary care physician be substituted to supervise the member's care.

(b) Each PCCM plan shall establish and operate a case management system, which shall assure continuity of care through appropriate referral of members needing specialty health services, documentation of referral services in member's medical records, monitoring of members with ongoing medical conditions, documentation in the member's medical records of emergency medical encounters with appropriate follow-up as medically indicated, and coordinated hospital discharge planning including necessary post-discharge care.

56310. Records.

(a) Each PCCM plan shall maintain or cause to be maintained all records necessary to verify information and reports required by statute, regulation or contractual obligation for three years from the date of submission of information or reports, except as specified in subdivision (b). Such records shall include but shall not be limited to:

(1) Working papers used in the preparation of reports to the Department.

(2) Reports to the Department.

(3) Financial documents.

(4) Medical records.

(5) Prescription files, if pharmacy services are provided under the contract.

(b) A PCCM plan shall retain or cause to be retained all records necessary to complete or accommodate an audit by state or federal agencies, if the audit is either in progress or the PCCM plan has been provided written notice of intent to audit prior to the expiration of the record retention requirements in subdivision (a). The records shall

be retained until the audit is complete and the records are released by the Department.

(c) A PCCM plan shall retain or cause to be retained all records pertaining to pending litigation or litigation in progress until the litigation is final.

56312. Reporting.

Each PCCM plan shall submit reports to the Department as specified below:

(a) Annual reports shall include:

(1) Any financial audit required by section 56340. This audit report shall be submitted no later than 90 calendar days after the close of the PCCM plan's contract year.

(2) Any disclosure statement required by the PCCM contract.

(b) Quarterly reports shall include:

(1) Utilization and statistical data in compliance with section 56314.

(2) Financial reports in compliance with section 56314.

(c) Child Health and Disability Prevention Program services rendered and health problems found shall be reported in accordance with sections 6800 through 6874, Title 17, California Code of Regulations.

(d) When changes occur, an update of any provider listing required under section 56242(b) shall be submitted within 30 calendar days of the change.

(e) Each PCCM plan shall submit to the Department a copy of any financial report submitted to any other government agency or public or private organization.

56314. Statistical Data.

(a) On a quarterly basis, each PCCM plan shall supply statistical data and information to the Department.

(b) The statistical data shall include but are not limited to:

(1) Utilization of services covered at risk.

(2) Costs of health care services covered at risk.

(3) General and administrative expenses.

(4) Unaudited financial statements.

56320. Capitation Payment.

(a) Payment to each PCCM plan shall be on a monthly capitation payment basis. Each PCCM plan shall be at risk for capitated services provided under the PCCM contract. The capitation payment shall:

(1) Constitute payment in full by the Department for health care and administrative services rendered under the PCCM contract.

(2) Be based upon a count of eligible members furnished to the PCCM plan monthly by the Department.

(b) The capitation payment shall not include payment for recoupment of any losses incurred by the PCCM plan under any prior contractual obligations with the State.

56321. Capitation Payment Rates Determination.

(a) The Department shall determine capitation payment rates annually by actuarial methods.

(b) The rates shall not exceed actuarially equivalent Medi-Cal fee-for-service costs. These costs shall be determined by viewing the total services at risk and requirements, including administration, provided under this chapter by a PCCM plan as though the same services and requirements, including administration, were reimbursable under Chapter 3 commencing with section 51001.

(c) The rates shall be effective for one year beginning the first day of July each year.

(1) In the event that payment of new rates is delayed beyond the first day of July, continued payment of the rate in effect shall be an interim payment only.

(2) Final payment shall be:

(A) Adjusted by increase or decrease to the level of the new rates.

(B) Effective as of the first day of July.

56322. Capitation Rate Redetermination.

(a) Capitation rates shall be redetermined during the rate year only when all of the following conditions are met:

(1) A change occurs in the obligations of the PCCM plan which results in increased or decreased costs of performing under the PCCM contract.

(2) The change in subdivision (1) is the result of either of the following:

(A) A change in federal or state law or regulation.

(B) A change in the Department's interpretation or implementation of federal or state law or regulation.

(3) The projected difference in the actuarial equivalent costs associated with the conditions set forth in subdivision (a)(2) exceeds one percent of the statewide average capitation rate for services covered at risk for the affected categories of members.

(b) The redetermination of capitation rates shall be subject to the approval of the appropriate state and federal control agencies.

(c) Rates redetermined pursuant to subdivision (a) shall be effective on the first day of the month in which the change in the obligations of a PCCM plan becomes effective. During the period of rate redetermination, continued payment of the rate in effect shall be interim payment only. Final payment shall be:

(1) Subject to increase or decrease to the level of the redetermined rates.

(2) Retroactive to the first day of the month in which the change in the obligations of a PCCM plan became effective.

56322.1. Savings Sharing.

(a) Notwithstanding section 56320, the Department shall calculate and disburse savings sharing to PCCM plans in accordance with the methodology and disbursement schedule specified in the PCCM contract.

(b) The savings sharing amount for a given PCCM plan is determined by comparing the expected fee-for-service cost for all services provided to PCCM plan members to the actual cost, which is the capitation payment plus the cost of noncapitated services paid through the fee-for-service system. If the expected fee-for-service cost exceeds the actual cost minus the State savings on the capitation payment, the difference is the amount saved, a portion of which is paid to the PCCM plan.

56324. Financial Resources.

(a) Each PCCM plan shall maintain adequate financial resources to carry out its contractual obligations. The Department shall determine the level of adequate financial resources for each PCCM plan by considering factors which include, but shall not be limited to, the following:

(1) Tangible net equity.

(2) Working capital trends.

(3) Profit and loss trends.

(4) Enrollment growth.

(b) Administrative costs incurred by a PCCM plan and its affiliates shall not exceed the limits established in the PCCM contract.

(c) Each PCCM plan shall at all times have and maintain a tangible net equity as specified in the PCCM contract.

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(1) Tangible net equity.

(2) Working capital trends.

(3) Profit and loss trends.

(4) Enrollment growth.

(b) Administrative costs incurred by a PCCM plan and its affiliates shall not exceed the limits established in the PCCM contract.

(c) Each PCCM plan shall at all times have and maintain a tangible net equity as specified in the PCCM contract.

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(1) Tangible net equity.

(2) Working capital trends.

(3) Profit and loss trends.

(4) Enrollment growth.

(b) Administrative costs incurred by a PCCM plan and its affiliates shall not exceed the limits established in the PCCM contract.

(c) Each PCCM plan shall at all times have and maintain a tangible net equity as specified in the PCCM contract.

56324. Financial Resources.

(a) Each PCCM plan shall maintain adequate financial resources to carry out its contractual obligations. The Department shall determine the level of adequate financial resources for each PCCM plan by considering factors which include, but shall not be limited to, the following:

(1) Tangible net equity.

(2) Working capital trends.

(3) Profit and loss trends.

(4) Enrollment growth.

(b) Administrative costs incurred by a PCCM plan and its affiliates shall not exceed the limits established in the PCCM contract.

(c) Each PCCM plan shall at all times have and maintain a tangible net equity as specified in the PCCM contract.

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(3) Profit and loss trends.

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(b) Administrative costs incurred by a PCCM plan and its affiliates shall not exceed the limits established in the PCCM contract.

(c) Each PCCM plan shall at all times have and maintain a tangible net equity as specified in the PCCM contract.

56326. Financial Security.

(a) Each PCCM plan that requests payment for medical services in advance of providing those services shall provide evidence of and maintain financial security. Financial security shall be maintained through the duration of the PCCM contract.

(b) Financial security may be in the form of, but is not limited to, one of the following:

(1) A guarantee bond.

(2) A letter of credit.

(3) A time certificate of deposit.

(4) A trust agreement.

(c) The Department shall approve the form and determine the amount of financial security required for each PCCM plan based on the projected number of enrollments and the applicable capitation rates.

(d) The Department may take possession of financial security sufficient to indemnify the Department in the event that the PCCM plan defaults on its contractual obligation to the Department.

56330. Affiliate.

Upon request by the Department every affiliate shall:
(a) Furnish to the PCCM plan and to the Department financial reports relevant to the disposition of funds paid to the affiliate by the PCCM plan. Reports shall be prepared according to generally accepted accounting principles and shall provide all financial data required by the PCCM plan to fulfill its obligations to the Department for financial reporting pursuant to these regulations and the PCCM contract.

(b) Make all books and records which are pertinent to PCCM plan contracts with the Department available for inspection by the Department and by the Department of Health and Human Services. These books and records shall be retained in accordance with section 56310.

56340. Financial Audit.

(a) A PCCM plan, not operated by a public entity, that has an average enrollment of 5,000 members per month or more in any three consecutive months within a contract year, shall have an audit performed at the close of the contract year by an independent certified public accountant. Regardless of enrollments, all PCCM plans not operated by a public entity shall have a independent certified public accountant perform an audit at least once every third year after the initial contract is signed with the Department.

(b) A PCCM plan operated by a public entity shall have an annual audit performed in a manner specified in the PCCM contract. The audit may be performed by, but is not limited to performance by:
(1) A certified public accountant.

(2) The county's financial accounting/audit department.

(3) The State's Auditor General office.

(c) Combined financial statements shall be prepared if the PCCM plan and an affiliate are substantially dependent upon each other for the provision of health care, management or other services. When a combined financial statement is required the independent accountant's report or opinion shall cover all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that a part of the examination was performed by another auditor, the PCCM plan shall also file the individual financial statements and report or opinion issued by the other auditor.

(d) PCCM plans which have subsidiaries that are required to be consolidated under generally accepted accounting principles shall present either consolidating financial statements, or consolidating schedules for the balance sheet and statement of operations, which in either case shall show the PCCM plan separate from the other entities included in the consolidated balances. Interentity transactions and profits shall be eliminated when combined statements are prepared.

(e) The PCCM plan shall authorize the independent accountant to allow representatives of the Department, upon written request, to inspect any and all working papers relating to the preparation of the audit report. The inspection shall:

(1) Be conducted at the accountant's place of business in California during normal business hours.

(2) Be conducted at the Department's headquarters in Sacramento, California, if the accountant's place of business is outside the State of California.

(3) Include supporting documentation, such as notes, computations, work sheets and rough drafts.

56350. Civil Penalties and Sanctions.

(a) The Department may, except as provided in section 56352(a), impose one or more of the civil penalties specified in subdivision (b) below upon a PCCM plan which fails to comply with the provisions of Chapter 7, Part 3, Division 9, Welfare and Institutions Code, the provisions of this chapter, or the terms of the PCCM contract.

(b) Civil penalties may include but are not limited to:

(1) Restricting the PCCM plan's marketing privileges.

(2) Delaying, or denying payment, in whole or in part, of savings sharing.

(3) Terminating the PCCM contract.

(4) Delaying or withholding capitation payments.

(5) Requiring the PCCM plan to terminate any subcontract or sub-subcontract.

(6) Other penalties as set forth in the contract.

(c) The Department shall issue a written notice of noncompliance to a PCCM plan found to be in violation of any provision of law, regulation or the contract. The notice of noncompliance shall include:

(1) A description of the violation.

(2) The penalties to be imposed by the Department.

(3) A description of any corrective action required by the Department and time limits for compliance.

56352. Contract Termination.

(a) The Department shall terminate a contract with a PCCM plan which the Secretary, Department of Health and Human Services has determined does not meet the requirements for participation in the Medicaid program stated in Title XIX of the Social Security Act.

(b) The Department may terminate a PCCM contract for noncompliance by the PCCM plan with the requirements of state or federal law or regulations or terms of the PCCM contract.

(c) The Department shall give 30 calendar days written notice prior to the termination of a PCCM contract to:

(1) The PCCM plan.

(2) PCCM plan members.

(3) Other entities, organizations, and persons that the Department deems appropriate.

(d) Notwithstanding subdivision (c), the contract shall be terminated immediately if the Department determines that:

(1) There is an immediate threat to the health of Medi-Cal beneficiaries enrolled in the PCCM plan; or,

(2) A state officer or state employee:

(A) Provides legal or management services to the PCCM plan, or

(B) Has a financial interest in:

1. The PCCM contract or PCCM contracting organization.

2. Any contract with the PCCM plan.

3. The procurement of a PCCM contract for the PCCM plan.

56400. Marketing.

(a) Each PCCM plan shall ensure compliance with all statutory, regulatory and contractual provisions relating to member enrollment and marketing activities.

(b) PCCM plan subcontractors shall not enter into any sub-subcontracts for marketing.

(c) Each PCCM plan shall establish an education program that assures that its marketing representatives have sufficient knowledge about the PCCM plan to explain how it operates to prospective and new members.

(d) A PCCM plan or marketing representative shall not adopt or utilize any procedure to identify prospective members who have medical or psychiatric problems, other than those specifically excluded from coverage by the PCCM contract, in order to exclude prospective members from enrollment in the PCCM plan.

(e) Marketing on county premises by PCCM plans is prohibited unless the marketing of prospective members is in accordance with Welfare and Institutions Code sections 14016.5 and 14016.6.

56401. Door-to-Door Marketing.

(a) PCCM plans may use door-to-door marketing only when all of the following conditions are met:

(1) The presenter is a marketing representative of the PCCM plan.

(2) Door-to-door marketing is performed only in the service area of the PCCM plan.

(3) The PCCM plan complies with this article and the terms of the PCCM contract.

(b) The Department may revoke door-to-door marketing privileges for any violation of the PCCM contract or applicable law or regulation.

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(b) The Department may revoke door-to-door marketing privileges for any violation of the PCCM contract or applicable law or regulation.

56404. Marketing Presentation.

Marketing presentations shall fully disclose the availability of, and restrictions upon the services provided by the PCCM plan. Such presentations shall, as a minimum, specify:
(a) The scope, access to, and availability of services.

(b) A description of the PCCM plan restricted Medi-Cal card which will authorize the member to obtain services.

(c) That members shall obtain all PCCM plan covered health care services rendered in nonemergency situations through the PCCM plan's providers.

(d) What emergency services are and that emergency services may be obtained at all times from specified PCCM plan providers or from non-PCCM plan providers, if necessary.

(e) That enrollment is voluntary.

(f) That enrollment is subject to a verification and processing period from 15 to 45 calendar days in length.

(g) The conditions under which disenrollment is possible.

56406. Misrepresentation.

(a) No marketing representatives or marketing organizations under contract with or employed by any PCCM plan shall in any manner misrepresent themselves, the PCCM plans they represent or the Medi-Cal program to induce enrollment.

(b) Violations of this section shall include, but shall not be limited to false or misleading claims that:

(1) Marketing representatives are employees or representatives of the federal government, state, county or anyone other than the PCCM plan.

(2) The PCCM plan is recommended or endorsed by any government organization or official.

(3) The federal government, state or county recommends that a Medi-Cal beneficiary enroll in a specific PCCM plan.

(4) A Medi-Cal beneficiary will lose benefits under the Medi-Cal program or any other health or welfare benefit to which the beneficiary is legally entitled, if the beneficiary does not enroll in a PCCM plan.

56408. Penalties for Misrepresentation.

The Department may impose one or more of the following penalties for violations of the provisions of this Article:

(a) Revoke one or more permitted method of marketing.

(b) Refuse to accept new enrollments for a period specified by the Department.

(c) Refuse to accept enrollments submitted by a specific marketing representative or organization.

(d) Withhold, deny or recover all or part of the capitation payment or savings sharing for persons enrolled as a result of the violations.

(e) Require that the PCCM plan personally contact each member enrolled in violation of this Article, explain the nature of the violation and inform the member of the right to disenroll.

(f) Terminate the PCCM contract.

56420. Member Enrollment.

(a) A Medi-Cal beneficiary is enrolled upon completion of all of the following events:

(1) The voluntary signing and dating of a designation form by the Medi-Cal beneficiary.

(2) Departmental validation of the beneficiary's designation form.

(3) Departmental verification of the beneficiary's Medi-Cal eligibility.

(4) Addition of the beneficiary's name to the approved list of members, furnished by the Department to the PCCM plan, which is effective at the first of any given month.

(b) Enrollment shall be voluntary.

(c) Enrollment shall be limited to Medi-Cal beneficiaries who reside within the PCCM plan's service area.

(d) A Medi-Cal beneficiary shall not be enrolled in more than one PCCM plan, Prepaid Health Plan, or any other Medi-Cal capitated plan providing the same services at any one time.

(e) Dependent minor children or persons legally judged incapable of acting on their own behalf may be enrolled in a PCCM plan by a parent, legal guardian or conservator.

56424. Designation Form Processing.

(a) PCCM plans shall submit all completed designation forms to the Department within 15 calendar days of the date the PCCM plan receives the completed designation form.

(b) Unless otherwise provided in writing by the Department, each PCCM plan shall accept designation forms from eligible Medi-Cal beneficiaries to the enrollment maximums specified in the PCCM contract.

(c) Each PCCM plan shall accept designation forms regardless of the prospective member's race, creed, color, religion, age, sex, national

origin, ancestry, marital status, sexual orientation, physical or mental handicap, and without reference to pre-existing medical conditions other than those specifically excluded from coverage by the PCCM contract.

56426. Term of Membership.

Except as provided in section 56440, membership shall continue indefinitely after enrollment. Membership shall be contingent upon the member's retention of Medi-Cal eligibility as well as eligibility for enrollment in the PCCM plan under the terms of the PCCM contract.

56440. Disenrollment of Members.

(a) A request for disenrollment by a PCCM plan member shall be submitted to the Department by the PCCM plan within five working days after either the date the member submits a signed disenrollment request directly to the PCCM plan or the postmark date for disenrollment requests sent by U.S. mail.

(b) Disenrollment of members for the following reasons shall be processed by the Department:

(1) The member's eligibility as a Medi-Cal beneficiary for enrollment in the PCCM plan is terminated.

(2) The enrollment is in violation of sections 56400, 56402, 56404, or 56406.

(3) Change of a member's place of residence outside the PCCM plan's service area.

(4) The member requests disenrollment.

(c) Requests for disenrollment in which the member states a reason for disenrollment shall be referred to the PCCM plan's grievance process in addition to submission to the Department as required in (a) above.

(d) Requests for disenrollment initiated by the PCCM plan shall be processed through the PCCM plan's grievance procedure and shall be based on the breakdown of the PCCM plan/member relationship.

(1) If the grievance procedure does not resolve the problem, the PCCM plan shall submit a written request to the Department for disenrollment of that member.

(2) The Department shall approve a PCCM plan-initiated disenrollment request only if efforts by the PCCM plan to counsel or modify the members behavior, including referral for mental health services, when appropriate, have been unsuccessful or are impossible or impractical given the circumstances, and if one or more of the following circumstances is documented:

(A) the member is repeatedly verbally abusive to PCCM plan providers, ancillary or administrative staff or other PCCM plan members.

(B) The member physically assaults a PCCM plan provider or staff person or PCCM plan member.

(C) The member is otherwise repeatedly disruptive to PCCM plan operations.

(D) The member repeatedly uses providers not affiliated with the PCCM plan for nonemergency services, causing the PCCM plan to be subjected to repeated provider demands for payment for services or other demonstrable degradation in the PCCM plan's relations with community providers.

(e) The Department shall, on an annual basis, develop a disenrollment processing schedule that assures that disenrollment occurs in compliance with applicable federal and state law and regulation. The Department shall revise the schedule, as necessary, to assure compliance, and shall provide reasonable notice to PCCM plans of the annual schedule and revisions to the schedule.

56442. Disenrollment Requests.

Members desiring disenrollment shall make written requests to the PCCM plan.

56450. Information to Prospective Members.

56452. Information to New Members.

Each PCCM plan shall provide to members, in writing, within seven days after the effective date of enrollment:
(a) The effective date of enrollment and the term of enrollment.

(b) A description of all available services and an explanation of any service limitations, exclusions from coverage, or charges for services when applicable.

(c) An explanation of the procedure for obtaining services.

(d) The name, telephone number and service site address of the primary care physician chosen by or otherwise made available to the member.

(e) An explanation of and the procedure for obtaining health service rendered in emergency circumstances occurring outside the PCCM plan's service area.

(f) The causes for which a member will lose entitlement to receive services from the PCCM plan.

(g) The procedure for processing and resolving any grievance by members. This information shall include the title, address, and telephone number of a person responsible for resolving grievances or initiating the grievance procedure and shall include an explanation of the member's right to request a fair hearing under Welfare and Institutions Code Section 10950, et seq., for unresolved grievances and to request a fair hearing without going through the PCCM plan's grievance procedures when a health care service requested by the member or a provider has not been provided.

(h) Disenrollment procedures, including an explanation of the member's right to disenroll without cause, and a disenrollment form.

(i) An explanation of the appropriate use of health care services and the contributions the member can make toward the maintenance of the member's own health.

56456. Notification of Changes in Services.

56500. Application and Proposal Information.

(a) Each applicant for a PCCM contract shall submit to the Department an application containing, but not limited to, the following information:

(1) A statement as to the optional services that will be selected in addition to the mandatory services required of PCCM plans.

(2) A brief description of any existing health care delivery system including information covering the scope and availability of services currently provided to Medi-Cal beneficiaries by the applicant.

(3) A description of the proposed PCCM plan health care delivery system. If the services are a duplicate of those described in (2), a

signed statement declaring that the health care delivery system will be the same will satisfy this requirement.

(4) A U.S. Postal Zip Code map with the proposed service area outlined in red.

(5) A separate list of all service area Zip codes in numerical order.

(6) A general area map of the service area that has all service sites distinctly identified and clearly listed on a legend.

(7) An array of the Medi-Cal population in the service area by PCCM plan eligible Medi-Cal Aid categories.

(8) A breakdown of the applicant's current patient population by private pay, insurance and Medi-Cal.

(9) A history of any experience the applicant has in providing care to patients through medical systems such as preferred provider organizations, industrial practice, prepaid health plans, PCCM plans, or any structured medical care delivery system that would demonstrate the ability to function as a PCCM plan.

(b) Each PCCM contract applicant approved by the Department shall submit a proposal containing, but not limited to, the following information:

(1) A description of the administrative structure which includes:

(A) An organization chart with the identification and functional description of each organizational unit, including corporate and medical management personnel.

(B) Complete background information for corporate and medical management personnel.

(C) Job descriptions for corporate and medical management personnel.

(D) A completed disclosure statement pursuant to section 56600.

(2) If applicable, a corporate structure chart identifying and displaying the relationships between the proposed PCCM plan and its

parent company, affiliates, subsidiaries, and any principal subcontractors.

(3) For each provider of health care services included in the PCCM plan, provide the following:

(A) Full name.

(B) Business address.

(C) Professional license number including the expiration date, where applicable; medical specialty including any certifying board, where applicable; and Medi-Cal provider number.

(D) Days and hours of operation for each provider.

(E) If an individual provider serves more than one site, list the days and hours of service for each site.

(4) A complete description of the procedures for internal and external referrals.

(5) A complete description of the system for providing or arranging for the provision of emergency services.

(6) Descriptions of the following medical administrative procedures:

(A) The proposed quality assurance, peer review, and utilization review programs.

(B) The proposed medical record system.

(C) The proposed provider grievance and complaint process.

(D) The procedures for provision of health education services.

(E) Proposed protocols for handling and disposing of infectious waste.

(7) Proposed protocols for medical care which includes age specific preventive health services.

(8) A description of the following proposed administrative procedures:

(A) Office procedures for missed appointment follow-up and the handling of emergency telephone calls.

(B) Marketing plan.

(C) Standard subcontract format.

(D) Tort liability protocols/procedures.

(E) The system for prompt reimbursement of nonplan providers for capitated services rendered to PCCM plan members.

(F) The system for complying with PCCM contract quarterly utilization and financial reporting requirements.

(9) A description of the following membership services:

(A) Enrollment procedures.

(B) The Statement of Understanding to be signed by each member.

(C) Member complaint process including a sample of the disposition notice, complaint log, and any related printed materials .

(D) The PCCM plan service guide.

(10) A listing and brief description of any existing government contract which involves current medical operations.

(11) A written statement that the PCCM plan will or will not accept the option of a risk limit.

(12) A description of activities that must be completed prior to contract implementation such as hiring staff, printing marketing materials and enrolling members.

(13) The following financial information:

(A) Detailed financial plan demonstrating the availability and sources of sufficient funds to cover operating costs for the first year of operation.

(B) Current income statement.

(C) Balance Sheet.

(D) Statement of Changes in Financial Position.

(E) A detailed cash flow budget, including all written assumptions, estimates and projections, demonstrating the availability and sources of funds to meet the obligations under the prospective contract. Projections shall include enrollment, income and expenses on a month-by-month basis for two years. Supporting budgets for affiliates shall be provided when the organization relies upon affiliates to provide services under the prospective contract.

(F) A projected calculation of tangible net equity.

(G) Certified financial statements, presented on a combined basis with all affiliates, as of the applicant's fiscal or calendar year end. No additional disclosures are required when the applicant's submission is within 90 calendar days after the end of the applicant's fiscal year. Unaudited financial statements to the most current quarter end shall also be submitted if the applicant's submission occurs prior to or more than 90 calendar days after the close of the applicant's fiscal year. Unaudited statements shall be prepared on a combined basis.

(H) A listing of all proposed subcontracts between the PCCM plan and affiliates.

(I) Proof of adequate professional liability insurance coverage.

(c) Each PCCM contract applicant approved by the Department shall submit the following certifications:

(1) A signed statement as to the willingness and ability of the applicant to revise policies or procedures as necessary or required by the Department.

(2) A signed statement as to the willingness and ability of the applicant to enroll members regardless of their race, creed, color, religion, age, sex, physical or mental handicap, sexual orientation, marital status, national origin or ancestry, and without reference to preexisting medical conditions other than those specifically excluded from converge under the PCCM contract.

(3) A signed statement to the effect that the applicant will not engage in selective enrollment marketing activities.

(4) A written statement that the applicant will maintain and operate a system which ensures the provision of or arrangement for CHDP services in close proximity to the primary care service site for eligible members.

56502. PCCM Contract Selection Criteria.

(a) The Department in exercising its discretion to enter into PCCM contracts shall evaluate applications, considering the following:

(a) Provider models that are able to offer the broadest base or reach particular segments of the Medi-Cal population, such as rural areas and Medicare/Medi-Cal beneficiaries. These provider models include, but are not limited to:

(1) Primary care clinics with specialists.

(2) Primary care clinics.

(3) Hospital based clinics.

(4) Group practices.

(5) Individual primary care physicians.

(6) Other models which offer potential for contracting, which shall be considered by the Department on an individual basis.

(b) Applicants who demonstrate sufficient resources to implement the PCCM contract, which include, but are not limited to:

(1) Support staff.

(2) Information systems.

(3) Organizational structure.

(4) Available capital.

(c) Applicants who provide the broadest range of optional services in addition to mandatory services.

(d) Applicants who will cover service areas that:

(1) Are in geographic areas which are free from competition from other PCCM or managed care plans.

(2) Have a significant enrollment pool based on the Department's estimated Medi-Cal beneficiary distribution patterns.

(3) Serve an area where PCCM plans exist or have existed and have not achieved significant enrollment given the service area or where the Department determines the Medi-Cal eligible population can support an additional plan.

(e) Applicants who have managed care or related experience, which includes but is not limited to:

(1) Subcontracting experience with PCCM plans.

(2) PHP experience.

(3) Industrial provider experience.

(4) Preferred provider experience.

56505. Contract Term.

56506. Contract Renewals.

56508. Mergers, Reorganizations or Assumptions.

(a) A PCCM plan shall submit proposals for mergers, reorganizations or assumptions to the Department for review.

(b) The Department may approve PCCM plan proposals relating to mergers, reorganizations or assumptions if, in addition to satisfying the requirements of section 14088 et seq., Welfare and Institutions Code as applicable, the following conditions are satisfied:

(1) The surviving organization meets the requirements of section 56500.

(2) The surviving organization provides written assurance that it will comply with all PCCM contract requirements and all applicable state and federal laws and regulations.

(c) The Department shall accept or reject the proposal within 60 calendar days of receipt of the proposal.

(d) Implementation of the proposal shall be accomplished by amendment of the PCCM contract.

56520. Public Notice.

(a) The Department shall publish a public notice of its intent to enter into a PCCM contract at least 60 calendar days prior to entering into an initial PCCM contract.

(b) The public notice shall appear in at least two major newspapers of general distribution in the service area of the proposed PCCM plan.

56600. Conflict of Interest.

(a) The Department shall terminate a PCCM contract, if the Department determines that a state officer or state employee:

(1) Provides legal or management services to a PCCM plan,

(2) Has financial interest in the PCCM contract or PCCM plan,

(3) Has any separate contract with the PCCM plan, or

(4) Is involved in the procurement of a contract or subcontract for any PCCM plan.

(b) The Department shall terminate a PCCM contract, if the Department determines that a PCCM plan fails to meet any of the following federal requirements:

(1) Disclosure of the identity of any person who has an ownership or control interest in the PCCM plan.

(2) Disclosure of the identity and circumstance surrounding any person who has an ownership or control interest in the PCCM plan who has been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid, or the Federal Social Security Act, Title XIX services program since the inception of the programs.

(3) Conditions required to obtain federal financial participation for the PCCM plan.

57000. Capital Expenditure Project.

(a) "Capital expenditure project" means a project for expenditures which, under generally accepted accounting principles, are not properly chargeable as expenses of operation and maintenance and are related to the acquisition, construction, renovation, improvement, modernization, expansion, or replacement of a plant, buildings, and equipment with respect to which the expenditure is made, including, but not limited to the following if included in revenue bond debt service:

(1) Studies, surveys, designs, plans, working drawings, and specifications bid preparation, inspection, and material testing;

(2) Site preparation, including demolishing or razing structures, hazardous waste removal, and grading and paving;

(3) Off-site construction and improvements required by the onsite project including the expansion of utilities, access roads, parking structures, bus stops, bus turnouts, bus shelters, and landscaping;

(4) Permit and license fees;

(5) Architectural, legal, accounting, contract administration cost and appraisal fees;

(6) Costs incurred for borrowing funds including capitalized interest; and

(7) Construction costs.

57003. Debt Service.

"Debt service" means principal and interest paid to holders of revenue bonds issued for the purpose of financing capital expenditure projects. Debt service may also include but is not limited to other debt service costs such as credit enhancement, debt service reserve funds, trustee fees, liquidity letters of credit, bond counsel or other costs of bond funding which may or may not be capitalized and reflected in the principal portion of debt service.

57006. Disproportionate Share Hospital.

"Disproportionate share hospital" means a hospital which serves a disproportionate number of low income patients as specified in the Medicaid State Plan Attachment 4.19-A., pages 18-29.

57009. Final Plans.

"Final plans" means those documents required by the Office of Statewide Health Planning and Development (OSHPD) and the Office of the State Architect which have been submitted to the OSHPD with Form OSH-FD 121 entitled "Application for Building Permit" as specified in the California Code of Regulations, Title 22, division 7, section 94037. In order to constitute "final plans" the box entitled "final plans" on the Form OSH-FD 121 shall be marked.

57012. Fixed Equipment.

"Fixed equipment" means equipment that is permanently affixed to the structure and which has a useful life determined in accordance with guidelines published by the American Hospital Association, entitled "Estimated Useful Lives of Depreciable Hospital Assets," 1983 and does not include:
(a) movable equipment;

(b) equipment that under generally accepted accounting principles is usually charged as an expense of operation and maintenance;

(c) items of current operating expense, such as food, fuel, pharmaceuticals, dressings, paper, printed forms, and house-cleaning supplies.

57015. New Debt.

"New debt" means funds resulting from the sale of revenue bonds used for financing a certified project as specified in section 57030 of this chapter for which final plans are submitted after July 1, 1989 and prior to June 30, 1994.

57018. Revenue Bond.

"Revenue bond" as defined in the California Government Code, division 3, Part 7.2, section 15459(c) means any bonds, warrants, notes, leases or installment sale obligations evidenced by certificates of participation, or other evidence of indebtedness issued by a local agency payable from funds other than the proceeds of ad valorem taxes or the proceeds of assessments levied without limitation as to rate or amount by the local agency upon property in the local agency.

57021. Three Most Recent Years.

"Three most recent years" means the three most recent calendar years.

57024. Supplemental Reimbursement.

"Supplemental reimbursement" for the purposes of this chapter means reimbursement by the Department to an eligible hospital pursuant to the provisions of the Welfare and Institutions Code, section 14085.5.

57027. Hospital Eligibility.

(a) In order to be considered eligible for supplemental reimbursement a hospital shall be determined an eligible hospital.

(b) A hospital shall meet both of the following conditions in order to be determined an eligible hospital:

(1) Be a disproportionate share hospital as defined in section 57006 of article 1, for the three most recent years, and

(2) Have entered into a contract to provide Medi-Cal inpatient hospital services pursuant to section 14082 of the Welfare and Institutions (W&I) Code, have entered into a contract with a county

organized health system pursuant to section 14087.5 of W&I or participate as a provider in a successor program.

57030. Capital Expenditure Project Certification.

(a) An eligible hospital's capital expenditure project or portion thereof shall be certified by the Department before supplemental reimbursement is made. In order to be certified or to remain certified, the capital expenditure project shall satisfy the following conditions:

(1) Final plans shall be submitted to the Office of Statewide Health Planning and Development and to the Office of the State Architect after July 1, 1989 and prior to June 30, 1994.

(2) Project funding shall be through the issuance of new debt.

(3) The hospital facilities being constructed, renovated, or replaced by the capital expenditure project shall be related to a covered service reimbursable by the Medi-Cal program and shall be available and accessible to Medi-Cal patients for the duration of the project debt reimbursement period.

(4) The capital expenditure project shall be for the construction, renovation, or replacement of the eligible hospital's facilities.

(5) The total capital expenditure project cost shall be not less than five million dollars ($5,000,000) unless the eligible hospital provides evidence that the project is necessary for the retention of federal and state licensing and certification and for meeting fire and life safety, seismic, or other regulatory standards.

(6) All supplemental reimbursement received by the eligible hospital shall be placed in a special account, the funds of which shall be used exclusively for the payment of debt service issued to finance the project or to reimburse the eligible hospital for debt service already paid for the project.

(7) The capital expenditure project shall finance the upgrading or construction of buildings and equipment to a level required by currently accepted medical practice standards, including projects designed to ensure that buildings and equipment meet the Joint Commission on Accreditation of Hospitals and Health Systems fire and life safety, seismic, or other related regulatory standards.

(b) The eligible hospital shall submit to the Department evidence that demonstrates that conditions set forth in subsection (a) of this section have been satisfied. Such evidence may include, but is not limited to copies of bank statements showing deposits and withdrawals, contracts, the official statement of the debt instrument, and the final plan date stamped by the Office of Statewide Health Planning and Development.

57033. Supplemental Reimbursement Calculation.

(a) The eligible hospital's supplemental reimbursement for a capital expenditure project which has been certified under section 57030 shall be calculated as follows:

(1) For each year in which the hospital is eligible to receive supplemental reimbursement, the hospital shall report to the Department the amount of debt service incurred for that portion of the capital expenditure project that represents the costs of the construction, renovation, or replacement of hospital facilities, including buildings and fixed equipment, which are available and accessible to Medi-Cal patients and provides services that are related to a covered service and reimbursable by the Medi-Cal program or successor program.

(2) The Department shall use the Medicaid inpatient utilization rate formula as specified in the Medicaid State Plan Attachment 4.19-A, pages 18-29, to determine the ratio of the hospital's total paid Medi-Cal patient days to total paid patient days.

(3) The supplemental reimbursement to the eligible hospital for each fiscal year shall equal the amount determined annually in subsection (a)(1) multiplied by the percentage resulting from dividing the number of Medi-Cal paid patient days by the total number of paid patient days.

(4) The supplemental reimbursement shall not be decreased by more than 10% of the initial ratio derived under subsection (a)(2) prior to the retirement of the debt.

57033. Supplemental Reimbursement Calculation.

(a) The eligible hospital's supplemental reimbursement for a capital expenditure project which has been certified under section 57030 shall be calculated as follows:

(1) For each year in which the hospital is eligible to receive supplemental reimbursement, the hospital shall report to the Department the amount of debt service incurred for that portion of the capital expenditure project that represents the costs of the construction, renovation, or replacement of hospital facilities, including buildings

and fixed equipment, which are available and accessible to Medi-Cal patients and provides services that are related to a covered service and reimbursable by the Medi-Cal program or successor program.

(2) The Department shall use the Medicaid inpatient utilization rate formula as specified in the Medicaid State Plan Attachment 4.19-A, pages 18-29, to determine the ratio of the hospital's total paid Medi-Cal patient days to total paid patient days.

(3) The supplemental reimbursement to the eligible hospital for each fiscal year shall equal the amount determined annually in subsection (a)(1) multiplied by the percentage resulting from dividing the number of Medi-Cal paid patient days by the total number of paid patient days.

(4) The supplemental reimbursement shall not be decreased by more than 10% of the initial ratio derived under subsection (a)(2) prior to the retirement of the debt.

57036. Reimbursement Provisions.

(a) If an eligible hospital's capital expenditure project has been certified pursuant to section 57030 and if appropriations for supplemental reimbursement of capital expenditure projects are available, supplemental reimbursement to the eligible hospital shall commence no later than 30 days after the department's receipt of the certificate of occupancy for the hospital's capital expenditure project issued by the Office of Statewide Health Planning and Development.

(1) In cases where the hospital must obtain a certificate of occupancy, the Department shall not be required to reimburse for debt service prior to its receipt of the certificate of occupancy.

(2) The frequency of the supplemental reimbursement shall correspond to the bond repayment schedule, but in no case shall the hospital be reimbursed more than twice per fiscal year.

(3) Supplemental reimbursement combined with reimbursement from all other sources dedicated exclusively for debt service shall be limited to no more than 100% (percent) of the debt service.

(b) Interest income realized from unexpended revenue bond funds shall reduce the reimbursement obligation under this section by the percentage figure derived from section 57033(a)(3).

(c) The information required by section 57033(a)(1) shall be reported separately for each hospital facility that is being constructed, renovated or replaced by the capital expenditure project.

(d) An eligible hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the Department's payment of supplemental reimbursement under this section.

(1) The Department shall offset any reduced federal financial participation against reimbursement otherwise due the eligible hospital either under this chapter or for services provided under the California Medical Assistance Program.

(2) The Department shall not deliver to the eligible hospital the amount of the federal financial participation in the debt service until the federal government approves federal financial participation for supplemental reimbursement made under this chapter and thereby supplements the Medicaid grant award for the Medi-Cal program.

(e) The Department may conduct periodic audits to determine if all requirements under this chapter have been met.

(1) Supplemental reimbursement made to eligible hospitals shall be subject to change based on final calculations when final Medi-Cal utilization data becomes available.

(2) If the final Medi-Cal utilization data, indicates that a hospital was not, in fact, a disproportionate share provider for the time period in which supplemental reimbursement was made, the hospital shall be obligated to return such supplemental reimbursements to the State.

(3) If the final Medi-Cal utilization data indicates that a hospital was either overpaid or underpaid, the Department shall make an adjustment to amounts the Department would otherwise pay to the hospital by reducing or augmenting the current supplemental reimbursement otherwise due under this chapter or due for services provided under the California Medical Assistance Program.

(f) As a condition of receiving supplemental reimbursement, the eligible hospital shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose supplemental reimbursement amounts to which the hospital is entitled.

57039. Continuing Eligibility.

(a) A hospital shall maintain eligibility and the capital expenditure project shall continue to meet the conditions set forth in 57030 for each year for which reimbursement is sought.

(b) Thirty (30) days prior to the anniversary of the certification date all documentation necessary to substantiate continued hospital eligibility and to maintain project certification, as required in this chapter, shall be submitted to the Department by the eligible hospital. The State shall not render supplemental reimbursement until all required documentation has been approved.

58000. Activities of Daily Living.

"Activities of Daily Living" means the verbatim definitions of California Insurance Code Sections 10232.8(f) and 10232.8(g) which must be used verbatim in Partnership Policies.

58001. Adult Day Health/Social Care.

"Adult Day Health/Social Care" means a structured, comprehensive program which provides a variety of community-based services including health, social, and related supportive services in a protective setting on a less than 24-hour basis. These community-based services are designed to meet the needs of functionally impaired adults through an individualized service plan, and include the following: personal care and supervision as needed, the provision of meals as long as the meals do not meet a full daily nutritional regimen, transportation to and from the service site, and social, health, and recreational activities. In California, providers of Adult Day Health/Social Care may include Adult Day Care Facilities as defined in Health and Safety Code Section 1502(a)(2), and Adult Social Day Care Facilities as defined in Health and Safety Code Section 1502.2, which are licensed by the Department of Social Services; Adult Day Health Care Facilities licensed by the Department of Health Services, pursuant to Health and Safety Code Section 1575 et seq.; and Alzheimer Day Care Resource Centers administered by the Department of Health Services pursuant to Health and Safety Code Section 1568.10 et seq.

58002. Average Daily Private Pay Rate for Nursing Facilities.

"Average Daily Private Pay Rate for Nursing Facilities" means the estimated average net revenue per patient day for intermediate and skilled nursing facility services for the current calendar year for patients not qualifying for Federal and State reimbursement. The net revenue per patient day is reported annually by each nursing facility to the Office of Statewide Health Planning and Development (OSHPD) and published annually in the OSHPD report entitled, "Aggregate Long Term Care Facility Financial Data". The published data lags the current year by two years. Therefore, the Department of Health Services will adjust the average net revenue per patient day for the most recent calendar

year published by OSHPD to estimate the increase in net revenue per patient day for the two years for which data is not available and thus estimate the average net revenue per patient day for the current calendar year. The average rate of increase in the net revenue per patient day for the most recent five years for which published data is available will be used to make the adjustment. The resulting Average Daily Private Pay Rate for Nursing Facilities for the upcoming calendar year will be rounded to the nearest ten dollars ($10) and distributed by the Department of Health Services in the Long Term Care Issuers' Bulletin.
Charges for ancillary services such as physical therapy, speech therapy, audiology, laboratory, as well as charges for patient supplies and legend prescription drugs are not included in the calculation of Average Daily Private Pay Rate for Nursing Facilities.

58003. Benefit Eligibility.

"Benefit Eligibility" in each Policy or Certificate is defined as follows:
(a) "How to qualify for Benefits: We will pay for the Qualified Long-Term Care Services covered by this policy if:
(1) The insured becomes a Chronically Ill Individual, and

(2) The Services are prescribed for the insured in a written Plan of Care.

(b) The insured will be considered a Chronically Ill Individual when one of the following criteria are met:
(1) The insured is unable to perform, without Standby Assistance or Hands-On Assistance from another individual, [2 Activities of Daily Living] due to a loss of functional capacity and the loss of functional capacity is expected to last at least 90 days; OR

(2) the insured has a Severe Cognitive Impairment requiring Substantial Supervision to protect the insured from threats to health and safety.

(c) The certification that the insured is a Chronically Ill Individual must be made by a Licensed Health Care Practitioner, within the preceding 12 months and must be renewed at least every 12 months. The services to be paid by the Policy [Certificate] must be prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner.

(d) All of the services covered by this policy are Qualified Long-Term Care Services.

(e) The definitions for the following terms will help explain how the insured qualifies for benefits under this Policy:

Activities of Daily Living;

Standby Assistance;

Hands-On Assistance;

Severe Cognitive Impairment;

Substantial Supervision;

Licensed Health Care Practitioner;

Plan of Care; and

Qualified Long-Term Care Services."

58004. California Partnership for Long-Term Care.

"California Partnership for Long-Term Care" means the program, authorized by Section 22000, et seq. of the California Welfare and Institutions Code, between the State of California and participating insurance companies that offer long-term care insurance Policies [Certificates], and provide Medi-Cal Asset Protection, that are approved as Partnership Policies [Certificates].

58005. Care Management/Care Coordination.

"Care Management/Care Coordination" includes, but is not limited to the following:
(a) the performance of a comprehensive individualized face-to-face assessment conducted in the client's place of residence;

(b) the development of a Plan of Care;

(c) the performance of a comprehensive, individualized reassessment at least every six months;

(d) when desired by the individual and determined necessary by the Care Management Provider Agency, coordination of appropriate services and ongoing monitoring of the delivery of such services; and

(e) the development of a discharge plan when the Care Management Provider Agency services, or the Policy benefits, are about to be terminated and if further care is needed. If the insured is immediately eligible for Medi-Cal, the Care Management Provider Agency shall prepare a transition plan.

Care Management/Care Coordination takes an all-inclusive look at a person's total needs and resources, and links the person to a full range of appropriate services using all available funding sources.

58006. Care Management Provider Agency.

"Care Management Provider Agency" means an agency or other entity that provides Care Management/Care Coordination and meets the standards set forth in Article 5.

58007. Care Management Supervisor.

"Care Management Supervisor" means a person who is an experienced Care Manager/Coordinator and is responsible for directing and supervising other Care Managers/Coordinators and undertaking duties as described in Section 58069.

58008. Care Manager/Coordinator.

"Care Manager/Coordinator" means a person who, either alone or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

58009. Certificate.

"Certificate" means any certificate of coverage issued under a group long-term care insurance policy, which policy has been approved for delivery in the State of California.

58010. Elimination Period.

"Elimination Period" is defined as either (a) or (b).
(a) "Elimination Period" means the total number of days that covered, Formal Long-Term Care Services must be received after the insured is determined to be a Chronically Ill Individual and before the benefits covered by the Policy or Certificate are payable. The number of days must be accumulated within a nine-month period [insurer option: a period longer than 9 months, but not shorter than 9 months can be used] after the insured has been determined to be a Chronically Ill Individual. The number of days can be accumulated before the filing of a claim if the insured can establish that he or she was a Chronically Ill Individual before filing a claim. The Elimination Period need only be met once during a lifetime. Any day when covered services [insurer option: days the insured receives inpatient care in a general acute care hospital may also be counted] are reimbursed by other insurance or Medicare may be counted toward meeting the Elimination Period. Respite Care [insurer option: list other benefits that are exempted] is not subject to the Elimination Period.

(b) "Elimination Period" means a provision that defines the number of days the insured must be disabled before the benefits covered by the

Policy or Certificate are payable, and that is approved by the Department of Health Services.

58011. Formal Long-Term Care Services.

"Formal Long-Term Care Services" means long-term care services for which the provider is paid.

58012. Hands-On Assistance.

"Hands-on Assistance" means the physical assistance of another person without which the insured would be unable to perform the Activity of Daily Living.

58013. Home Health Care Services.

"Home Health Care Services" means skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

58014. Elimination Period.

58015. Formal Long-Term Care Services.

58016. Home Health Care Services.

58017. Homemaker Services.

"Homemaker Services" means assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a Licensed Health Care Practitioner.

58018. Hospice Services.

"Hospice services" are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

58019. Informal Long-Term Care Services.

"Informal Long-Term Care Services" means long-term care services for which the provider is not paid.

58020. Issuer.

"Issuer" means an entity delivering or issuing for delivery in this State, Partnership Long-Term Care Insurance Policies or Certificates, as follows:
(a) insurers, as defined in Section 23, California Insurance Code;

(b) fraternal benefit societies, as defined in Section 10990, California Insurance Code;

(c) any similar organization regulated by the Commissioner of the Department of Insurance pursuant to Section 12921, California Insurance Code; or

(d) The California Public Employees' Retirement System Board of Administration.

58021. Licensed Health Care Practitioner.

"Licensed Health Care Practitioner" means any physician (as defined in Title 42, United States Code, Section 1395x(r)(1)) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. The Licensed Health Care Practitioner must be employed by a Care Management Provider Agency or be a Qualified Official Designee of a Care Management Provider Agency.

58022. Long-Term Care Services Countable Toward Medi-Cal Property Exemption.

"Long-Term Care Services Countable Toward Medi-Cal Property Exemption" means those services that may be covered in a Policy or Certificate which will qualify for the Medi-Cal Property Exemption. These services include the following:

(a) long-term care in nursing facilities, as defined in Sections 51120 and 51123;

(b) home health services, as defined in Section 51337;

(c) home and community-based services approved under 42 U.S.C. Section 1396n(c), and provided in the Welfare and Institutions Code, Section 14132(s) and (t);

(d) Residential Care Facility Services;

(e) personal care services as defined in California Code of Regulations, Title 22, Section 51183;

(f) adult day health care services as defined in California Code of Regulations, Title 22, Section 54103;

(g) hospice services as defined in California Code of Regulations, Title 22, Sections 51180 through 51180.7; and

(h) other services approved by the Department of Health Services.

58023. Medi-Cal Asset Protection.

"Medi-Cal Asset Protection" means the right extended to the insured by California when the insured uses the benefits of this Policy. This right allows the insured to protect one dollar of assets for every dollar this Policy pays out in benefits, in the event the insured later applies for Medi-Cal benefits or for other qualifying State long-term care benefits. The amount of this asset protection at any time is equal to the sum of all benefit payments made for the insured's care by this Policy. Should the insured later apply for Medi-Cal benefits or for other qualifying public long-term care benefits, he or she will not be required to expend the protected assets prior to becoming eligible for these public benefits. The insured's protected assets will also be exempt from any claim the State of California may have against his or her estate to recover the costs of State-paid long-term care or medical services provided to the insured.

58024. Medi-Cal Property Exemption.

"Medi-Cal Property Exemption" means the total equity value of real and personal property not otherwise exempt under Medi-Cal regulations (California Code of Regulations, Title 22, Section 50000 et seq.) equal to the sum of qualifying insurance benefit payments made on behalf of the insured.

58025. Partnership Long-Term Care Insurance Policy or Certificate, or Partnership Policy or Certificate.

"Partnership Long-Term Care Insurance Policy or Certificate" or "Partnership Policy or Certificate" means any long-term care insurance Policy or Certificate approved by the Department of Health Services and the Department of Insurance for issue or delivery to California residents as meeting the requirements set forth in Section 22005(e) of the Welfare and Institutions Code.

58026. Personal Care Services.

"Personal Care Services" means:
(a) Ambulation assistance, including help in walking or moving around (i.e. wheelchair) outside or inside the place of residence, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation assistance does not include movement solely for the purpose of exercise.

(b) Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

(c) Dressing including putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(d) Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

(e) Repositioning, transfer skin care, and range of motion exercises, including moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. Motion exercises shall include the carrying out of maintenance programs, i.e. the performance of the repetitive exercises required to maintain function, improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

(f) Feeding, hydration assistance, including reaching for, picking up, grasping utensil and cup; getting food on utensil; bringing food, utensil, cup to mouth, and manipulating food on plate. Cleansing face and hands as necessary following meal.

(g) Assistance with self-administration of medications.

(h) Assistance with Instrumental Activities of Daily Living, which include:
(1) domestic or cleaning services;

(2) laundry services;

(3) reasonable food shopping and errands;

(4) meal preparation and cleanup;

(5) transportation assistance to and from medical appointments; and,

(6) heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt; and,

(7) using the telephone.

(i) Partnership Long-Term Care Insurance Policy or Certificate shall not, if it provides Personal Care Services, limit or exclude benefits by requiring that the provision of Personal Care Service be at a level of certification or licensure greater than that required by the eligible service, or by limiting benefits to services provided by Medicare-certified agencies or providers.

58027. Plan of Care.

"Plan of Care" means a written individualized plan of services prescribed by a Licensed Health Care Practitioner which specifies the type, frequency, and providers of all Formal and Informal Long-Term Care Services required for the individual, and the cost, if any, of any Formal Long-Term Care Services prescribed. Changes in the Plan of Care must be documented to show that such alterations are required by changes in the client's medical situation, functional and/or cognitive abilities, behavioral abilities or the availability of social supports.

58028. Policy.

"Policy" means any contract, rider, or endorsement delivered or issued for delivery in the State of California by an Issuer.

58029. Qualified Long-Term Care Services.

"Qualified Long-Term Care Services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal services which are

needed to assist the insured with the disabling conditions that cause the insured to be a Chronically Ill Individual.

58030. Qualified Official Designee of a Care Management Provider Agency.

"Qualified Official Designee of a Care Management Provider Agency" means an individual who meets the Care Manager/Coordinator qualifications and is designated by the Care Management Provider Agency to certify the insured is a Chronically Ill Individual and/or to perform Care Management/Care Coordination.

58031. Quarterly/Annually.

"Quarterly/Annually", unless otherwise stated, refers to periods aligned with the State Fiscal Year of July 1 to June 30.

58032. Residential Care Facility.

"Residential Care Facility" means a facility licensed as a Residential Care Facility for the Elderly or a residential care facility as defined in the California Health and Safety Code. Outside California, eligible providers are facilities licensed or certified by the appropriate state agency to provide ongoing care and related services sufficient to support needs resulting from an inability to perform Activities of Daily Living or Severe Cognitive Impairment or if no licensure or certification is required, facilities engaged primarily in providing on-going care and related services sufficient to support needs resulting from an inability to perform Activities of Daily Living or Severe Cognitive Impairment and which also:
(a) provide such care and services on a twenty four (24) hour a day basis; and

(b) have a trained ready-to-respond employee on duty in the facility at all times to provide such care and services; and

(c) provide three meals a day and accommodates special dietary needs; and

(d) have arrangements to ensure that residents receive the medical care services of a physician or nurse in case of emergency; and

(e) have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

58033. Respite Care.

"Respite Care" means the supervision and care of Chronically Ill Individuals in the home or out of the home while the family or other

individuals who normally provide care take short-term leave or rest that provides them with temporary relief from the responsibilities of caregiving.
A Partnership Long-Term Care Insurance Policy or Certificate shall not, if it provides Respite Care, limit or exclude benefits by requiring that the provision of Respite Care be at a level of certification or licensure greater than that required by the eligible service or by limiting benefits to services provided by Medicare-certified agencies or providers.

Eligible providers for Respite Care include: a Nursing Facility, a Residential Care Facility, community-based programs such as an Adult Day Health/Social Care provider, persons employed by a home health agency, and a person who is qualified by training and/or experience to provide the care.

58034. Service Summary.

"Service Summary" means a written summary, prepared by an issuer for a qualified insured, which identifies the following:
(a) the Partnership Policy or Certificate,

(b) the total benefits paid for services as of the end of the previous quarter,

(c) the total benefits paid for services in the current quarter,

(d) the total amount of benefits paid as of the end of the previous quarter qualifying for a Medi-Cal Property Exemption,

(e) The total amount of benefits paid for services in the current quarter qualifying for a Medi-Cal Property Exemption, and

(f) remaining benefit amount.

58035. Severe Cognitive Impairment.

"Severe Cognitive Impairment" means a loss or deterioration in intellectual capacity that:
(a) is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and;

(b) is measured by clinical evidence and standardized tests prescribed or approved by the California Partnership for Long-Term Care.

58036. Shortened Benefit Period Nonforfeiture Benefit.

"Shortened Benefit Period Nonforfeiture Benefit" means that, when premiums cease being paid, the covered benefits will be paid by the Issuer at the rate specified in the Partnership Policy or Certificate but the lifetime maximum benefit payable will be reduced to an amount

less than provided in the Partnership Policy or Certificate at date of issue.

58037. Standby Assistance.

"Standby Assistance" means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing an Activity of Daily Living (such as being ready to catch insured if he or she falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the insured's throat if he or she chokes while eating).

58038. Substantial Supervision.

"Substantial Supervision" means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect a person who has Severe Cognitive Impairment from threats to his or her health or safety (such as may result from wandering).

58050. Issuer Requirements.

(a) Each issuer must offer, prominently advertise, and actively market a Partnership Comprehensive Policy or Certificate (paying benefits on an expense incurred or expense reimbursable basis) that contains the following minimum benefits:

(1) a lifetime maximum benefit set in dollars and equivalent in dollars to three hundred sixty-five (365) times eighty percent (80%) of the Average Daily Private Pay Rate for Nursing Facilities;

(2) a thirty-day Elimination Period;

(3) coverage for services in a nursing facility and coverage of the home and community-based care services as specified in Section 58059(e);

(4) a Respite Care benefit not subject to an Elimination Period;

(5) Care Management/Care Coordination;

(6) except for previously approved Partnership Policies, if offered on an expense reimbursable basis,

(A) a nursing facility per diem benefit of eighty (80%) of the Average Daily Private Pay Rate for Nursing Facilities, rounded to the nearest multiple of ten dollars ($10);

(B) a Residential Care Facility benefit;

(C) a monthly home and community-based care benefit of fifty percent (50%) of the nursing facility per diem benefit contained in the Partnership Policy or Certificate multiplied by thirty; and

(D) automatic increases of five percent (5%) each year over the previous year for each year the contract is in force for all covered benefits and for the lifetime maximum benefit;

(7) except for previously approved Partnership Policies if offered on an expense incurred basis,

(A) benefits that pay eighty percent (80%) of the costs incurred by the insured for nursing facility services up to eighty percent (80%) of the Average Daily Private Pay Rate for Nursing Facilities, rounded to the nearest one dollar ($1);

(B) benefits that pay eighty percent (80%) of the costs incurred by the insured for care in a Residential Care Facility up to fifty percent (50%) of the Average Daily Private Pay Rate for Nursing Facilities, rounded to the nearest one dollar ($1);

(C) benefits that pay eighty percent (80%) of the costs incurred by the insured for home and community-based care;

(D) a lifetime maximum benefit that automatically increases by five percent (5%) each year over the previous year for each year the contract is in force; and

(8) all other benefits and provisions defined in Sections 58059(f), (g) and (l), 58060, and 58061.

(b) Issuers are not required to offer a Partnership Nursing Facility and Residential Care Facility Only" Policy or Certificate (paying benefits on an expense incurred or expense reimbursable basis), except as provided in Section 58061(c)(3). If the issuer elects to offer such a Policy or Certificate, the policy shall display prominently on page one (1) of the Policy or Certificate: "Nursing Facility and Residential

Care Facility Only" Policy [Certificate]. The issuer must also offer, prominently advertise, and actively market a Partnership Policy or Certificate that contains the following minimum benefits:

(1) a lifetime maximum benefit set in dollars that is equivalent in dollars to three hundred sixty-five (365) times eighty percent (80%) of the Average Daily Private Pay Rate for Nursing Facilities;

(2) a thirty-day Elimination Period, and the Elimination Period definition used verbatim;

(3) coverage for services in a nursing facility and a Residential Care Facility as specified in Section 58059(d);

(4) Care Management;

(5) If issued on an expense reimbursable basis,

(A) a nursing facility per diem benefit of eighty percent (80%) of the Average Daily Private Pay Rate for Nursing Facilities, rounded to the nearest multiple of ten dollars ($10);

(B) a Residential Care Facility Benefit of fifty percent (50%) of the nursing facility per diem benefit contained in the Partnership Policy or Certificate;

(C) automatic increases of five percent (5%) each year over the previous year for each year the contract is in force for all covered benefits and for the lifetime maximum benefit;

(6) if issued on an expense incurred basis,

(A) benefits that pay eighty percent (80%) of the costs incurred by the insured for nursing facility services up to eighty percent (80%) of the Average Daily Private Pay Rate for Nursing Facilities, rounded to the nearest one dollar ($1);

(B) benefits that pay eighty percent (80%) of the costs incurred by the insured for care in a Residential Care Facility up to fifty percent (50%) of the Average Daily Private Pay Rate for Nursing Facilities, rounded to the nearest one dollar ($1);

(C) a lifetime maximum benefit that automatically increases by five percent (5%) each year over the previous year for each year the contract is in force; and

(7) all other benefits and provisions specified in Sections 58059(f), (g) and (l), 58060 and 58061.

(c) If any Issuer elects to offer and market a Partnership Policy or Certificate with lifetime maximum benefits in amounts greater than the minimum, the Issuer must offer Policies or Certificates with lifetime benefit maximums in amounts equal to seven hundred thirty (730) times and one thousand ninety-five (1095) times the Average Daily Private Pay Rate for Nursing Facilities and with Elimination Periods of both thirty (30) and ninety (90) days.

(d) Issuers of Partnership group Policies to employers may use normal underwriting and age criteria, but may only issue Policies to those employers who agree to make Certificates available to all individuals within one of the following groups:

(1) active employees and retirees, the active employees' and retirees' spouses, and the parents of all employees and their spouses, who are California residents; or,

(2) retirees, the retirees' spouses and the parents of retirees and their spouses, who are California residents.

(e) Social underwriting, defined as refusal to issue an insurance Policy or Certificate based upon non-medical primary determinants, is prohibited. However, social factors may be considered when pricing a Partnership Policy or Certificate for applicants, so long as a clear rationale for the pricing differential and associated premium impact is submitted to the California Partnership for Long-Term Care. Non-medical factors unacceptable for use as primary determinants when refusing to issue a Policy or Certificate include; the applicant's gender; marital status; living arrangements; sexual preference; presence or absence of an assumed support network (for example but not limited to family, church, community), including health status of probable caretaker spouse; current or past occupation except with respect to group Policies or individual Policies issued by Issuers that are precluded by their charter or bylaws from selling to the general public; hobbies, except recognized high risk pursuits; educational level; and geographic location within California.

(f) All Partnership Policies or Certificates issued by the Issuer, whether initial Partnership Policies or Certificates, upgrades to Partnership Policies or Certificates, and/or replacements for Partnership Policies and Certificates, shall bear the same Policy or Certificate form number and use an additional unique identifier to designate subsequent versions of the initial Policies and Certificates. All individual Partnership Policies, upgrades and/or replacements of

Partnership Policies shall be considered a single risk pool for purposes of approving any future premiums adjustments with the following exception. A group Issuer may form a separate risk pool whenever at least two thousand (2000) Certificates are in force for a single employer, labor organization, or trust established by a single employer or labor organization, for a single nonprofit association composed of individuals who are or were actively engaged in the same profession, trade, or occupation and organized in good faith for purposes other than obtaining insurance, and for a single nonprofit association created and maintained in good faith for the benefit of its members and not for the purposes of obtaining insurance, in active existence for at least five years, and with a constitution and bylaws and a board with member representation. Nothing in this section, however, shall preclude an Issuer of non-Partnership policies from pooling the non-Partnership policies with Partnership Policies or Certificates to avoid or reduce the amount of any future premium increase that otherwise might have occurred to the risk pool of Partnership Policies and Certificates.

(g) Long-term care insurance policies or certificates that are not approved under the California Partnership for Long-Term Care must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box. The required statement, to appear verbatim, on all non-Partnership policies and certificates issued or delivered sixty (60) days or more after the first Partnership Policies or Certificates have been filed with the Department of Insurance will read as follows:

"THIS POLICY [CERTIFICATE] IS AN APPROVED LONG-TERM CARE INSURANCE POLICY [CERTIFICATE] UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS POLICY [CERTIFICATE] WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE.

FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1 (800) 434-0222."

The required statement may omit the last sentence giving the telephone number to call for information about the California Partnership for Long-Term Care where an Issuer offers both Partnership and non-Partnership policies or certificates simultaneously in a single application or solicitation to all individuals within either of the groups described in Subsections (d)(1) and (d)(2).

(h) Issuers are responsible for contracting with one or more Care Management Provider Agencies that meet the standards described in Article 5.

(i) Notwithstanding the provisions of Subsection (c), above, an Issuer that elects to offer or market a Partnership Policy or Certificate of lifetime maximum benefits in amounts greater than the minimum required for approval may offer lifetime maximum benefits with amounts equal to seven hundred thirty (730) times the Average Daily Private Pay Rate for Nursing Facilities, or to one thousand ninety-five (1095) times the

Average Daily Private Pay Rate for Nursing Facilities, or both, and with Elimination Periods of thirty (30) or ninety (90) days, or both, provided that the offering is made on a non-discriminatory basis to all individuals within one of the following groups:

(1) active employees and retirees, the active employees' and retirees' spouses, and the parents of all employees and their spouses, who are California residents; or,

(2) retirees, the retirees' spouses and the parents of retirees and their spouses, who are California residents.

(j) Each Issuer shall:

(1) maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term insurance policies sold by the agent as a percent of the agent's total annual sales;

(2) report annually by June 30, the 10 percent of its agents in the state with the greatest percentage of lapes and replacements as measured by section (j)(1);

(3) report annually by June 30, the number of lapsed policies as a percent of its total annual sales in the state, as a percent of its total number of policies in force in the state, and as a total number of each policy form in the state, as of the end of the preceeding calendar year; and,

(4) report annually by June 30, the number of replacement policies sold as a percent of its total annual sales in the state and as a percent of its total number of policies in force in the state as of the end of the preceding calender year.

58051. Targeting Requirements.

(a) Issuers may issue or deliver Partnership individual Policies or Certificates to California residents only.

(b) Issuers are responsible for taking appropriate measures to assure that a substantial number and proportion of their total sales of Partnership Policies or Certificates each year are to individuals within the target population. The target population for the purchase of a Partnership Policy or Certificate or replacement of current long-term care coverage with a Partnership Policy or Certificate is California residents between the ages of 55 and 74 years old with assets greater than 365 times eighty percent (80%) of the Average Daily Private Pay Rate for Nursing Facilities and with annual incomes less than the seventy-fifth (75) percentile for their age cohort, provided that the

annual premium for the Partnership Policy or Certificate does not exceed seven percent (7%) of the prospective purchaser's annual income. The California Partnership for Long-Term Care shall annually distribute to participating Issuers the annual incomes equivalent to the seventy-fifth (75) percentile in the target populations based on data from the U.S. Department of Commerce, Bureau of the Census Current Population Survey.

Individuals with ages outside the target population, and/or with assets lower or incomes higher than the target population, are eligible to purchase Partnership Policies or Certificates.

(c) Each prospective Issuer, prior to approval by the Department of Health Services, shall submit a detailed marketing plan describing the Issuer's strategy for marketing a substantial number and proportion of their total sales of Partnership Policies and Certificates to the target population. The Issuer's marketing plan will cover the following issues:

(1) identify the primary and secondary markets and how marketing efforts directed to these markets will result in sales to individuals in the target population;

(2) describe the distribution and sale system to be used, the marketing methods to be used, and how these are appropriate to reach the target population;

(3) detail the resources and materials to be used and how these will result in sales to the target population; and

(4) describe the methods to be used to monitor success in marketing a substantial portion of their Partnership Policies and Certificates to the target population.

(d) Each Issuer will annually, by July 1, submit to the Department of Health Services an assessment of the number and proportion of sales made during the prior year to the target population and an updated market plan for the next year.

(e) Participating Issuers will cooperate in evaluation studies to measure the success of efforts to reach the target population by mailing surveys prepared by The California Partnership for Long-Term Care to a representative sample of their California policy or certificate holders who purchase non-Partnership policies or certificates. Participating insurers shall also submit individual level data on their sales of non-Partnership policies for the prior year to the Department by March 31.

(f) Each prospective Issuer shall each year contribute to a fund to be used for common educational and marketing expenses for reaching the target population in an amount to be negotiated by the California Partnership for Long-Term Care and the participating Issuers. The

amount of each participating Issuer's required annual contribution will in no case be lower than $10,000 or the equivalent of $10,000 in "in-kind" services.

(g) Issuers shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement in accordance with the criteria for the target population and Insurance Code Sections 10234.95, 10235.16, and 10235.17.

(h) Participating Issuers who replace existing policies and certificates with Partnership Policies or Certificates, or who replace Partnership Policies or Certificates, shall forward to the Department of Health Services one copy of the "Notice To Applicants Regarding Replacements of Accident and Sickness or Long-Term Care Insurance" required under the Insurance Code Section 10235.16(b) and (d).

The fact that a Partnership Policy or Certificate provides a Medi-Cal Property Exemption shall not in itself, without otherwise determining the appropriateness of the replacement of current long-term care coverage, be deemed as a transaction that materially improves the individual's position within the meaning of Insurance Code Section 10235.16(d).

(i) Agents shall make reasonable efforts to avoid selling Partnership Policies or Certificates to Medi-Cal beneficiaries unless:

(1) a third party pays the premium; and

(2) both the prospective Policy or Certificate holder and the third party sign a statement acknowledging that the applicant is a Medi-Cal beneficiary but wants private coverage for which the third party will pay the premium. The statement must be submitted with the application and shall be retained in the Issuer's files.

(j) Issuers shall not issue or deliver a Partnership Long-Term Care Insurance Policy or Certificate with knowledge that the individual is entitled to benefits under another long-term care insurance policy or certificate, unless:

(1) the existing policy is in force under a non-forfeiture benefit provision; or

(2) the existing policy or certificate is being replaced by issuance or delivery of the new Partnership Policy or Certificate.

58052. Marketing and Disclosure Requirements.

(a) Every Issuer shall submit a copy of any advertisements, educational and/or sales materials intended for use with Partnership Policies or Certificates to the Department of Health Services for review and approval at least thirty (30) days before dissemination. These

materials are deemed approved unless the Department of Health Services formally disapproves them within thirty (30) days of receipt.

(b) Policies or Certificates deemed to meet the requirements of this Chapter shall be designated by the presence of the official logo of the California Partnership for Long-Term Care. The official logo shall be printed on every Partnership Policy or Certificate, and all application forms, sales materials, and other information used by the Issuer in conjunction with the sales and marketing of Partnership Policies and Certificates. Subject to the conditions in this Section, all materials bearing this logo must be reviewed and approved by the Department of Health Services.

(c) No long-term care insurance Policy or Certificate may be advertised, solicited, or issued for delivery in this state as a Partnership Long-Term Care Insurance Policy or Certificate unless the Issuer does the following:

(1) provides the Department of Health Services with a written summary of the methods the Issuer will use to alert the consumer, prior to presentation of an application for a Partnership Policy or Certificate, of the availability of consumer information and public education provided by the California Department of Aging's Health Insurance Counseling and Advocacy Program;

(2) uses applications to be signed by the applicant which indicates, that the applicant;

(A) received, prior to the presentation of an application or enrollment form, a complete description of the California Partnership for Long-Term Care in a form and format prepared by the Department of Health Services, including an explanation of Asset Protection provided by the program and how it is achieved and the Health Insurance Counseling and Advocacy Program's toll free consumer information number; and

(B) received, prior to the presentation of an application or enrollment form, a copy of a long-term care insurance shoppers guide approved by the California Partnership for Long-Term Care; and

(C) received a statement regarding Medi-Cal eligibility and benefits that shall be in the following format:

"NOTICE TO APPLICANT REGARDING MEDI-CAL ELIGIBILITY

I understand that eligibility for Medi-Cal is not automatic; an application is necessary. Once my long-term care insurance begins paying benefits, the insurer will send me quarterly statements showing how much asset protection I have earned. This permanent asset protection is in addition to any asset exemptions available to any Californian applying for Medi-Cal. I understand that should I want to apply for Medi-Cal it is my responsibility to complete the application

process. I further understand that before receiving Medi-Cal I will first have to use any additional assets I have not protected. If I become a Medi-Cal beneficiary, I understand that I may have to apply a portion of my income toward the cost of my care, and that Medi-Cal services at that time may not be the same services I was receiving under my private long-term care insurance.

_____ (Signature of Applicant(s))"

(D) agrees to the release of information by the Issuer to the State as may be needed to evaluate the California Partnership for Long-Term Care and to provide the necessary verification to document the applicant's Medi-Cal Property Exemption, in the following format:

"CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long-term care insurance policy or certificate to the State of California for the purposes of documenting my Medi-Cal asset disregard under the Medi-Cal program, evaluating the California Partnership for Long-Term Care, and meeting Department of Health Services or Department of Insurance audit or quality control requirements.

As part of the evaluation of the California Partnership for Long-Term Care, the State is trying to determine how well this program is reaching people with varying amounts of income and assets. You will therefore be asked to fill out a brief survey, prepared by the State, and indicate what range your income and assets fall into.

I understand that the information contained in these records will be used for no purpose other than those stated above, and will be kept strictly confidential by the State of California.

_____ (Signature of Applicant(s))"

(E) Received a graphic comparison in a form provided by the California Partnership for Long-Term Care showing the benefit levels of a Policy or Certificate that increases benefits at a compounded annual rate of not less than five percent (5%) over the Policy or Certificate period with a policy or certificate that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period. The comparison will also illustrate the costs the Policy or Certificate holder would pay out of their own income or assets for nursing home care between a Policy or Certificate that does not increase benefits and;

1. an expense reimbursable Policy or Certificate that increases benefits but not premiums over the Policy or Certificate period; and

2. an expense incurred Policy or Certificate that increases premiums and benefits over the Policy or Certificate period.

(F) Received a statement regarding the absence of a Medi-Cal residential care facility benefit if the application is for a Nursing Facility and Residential Care Facility Only Policy or Certificate with the following features:

1. Benefit Eligibility is based on deficiencies in two Activities of Daily Living; and

2. the lifetime maximum benefit is less than seven hundred thirty (730) times the Nursing Facility per diem benefit.

(G) Issuers that market by direct mail response without sales agents will meet the requirements of Subsections (c)(2)(A) and (B), above, by using applications, to be signed by the applicant, that indicate the applicant received the specified publications and information prior to completing the application or enrollment form.

58053. Conversion of Policies or Certificates.

(a) Conversion of Non-Partnership Policies or Certificates to Partnership Policies.

Each participating Issuer which has previously sold non-Partnership long-term care insurance policies or certificates shall make the following provisions for its policy or certificate holders who are not in benefit status or in the process of satisfying the policy or certificate elimination period;

(1) Individual policy holders who hold non-Partnership policies on the date when the participating Issuer's Policy is first available for purchase shall have a right to convert to a Partnership Policy at any time during the period the Issuer is a participating Issuer. However, the policy holder's right to convert may be limited to one-time only if the Issuer elects to provide written notification to each individual policy holder of the right to convert to a Partnership Policy within twelve months (12) of the date the participating Issuer is approved and allows the policy holder a minimum window of at least sixty (60) days to convert to a Partnership Policy.

(2) Each holder of a non-Partnership certificate shall be afforded the right to convert to a Partnership Certificate if the employer or entity who holds the group policy elects to make available a Partnership Certificate to any of its employees or members. If the

employer or entity so elects, the holders of non-Partnership certificates shall be provided written notification and allowed, at minimum, a window of at least sixty (60) days to convert to a Partnership Certificate.

(3) Except as provided in (4) below, participating Issuers shall allow current policy or certificate holders to convert to a Partnership Policy or Certificate based upon full underwriting criteria no more stringent than if the policy or certificate holder were applying for coverage under a certified Policy or Certificate.

(4) Participating Issuers shall allow current policy or certificate holders with policies or certificates in effect for less than twenty-four (24) months to convert to a Partnership Policy or Certificate based on underwriting criteria no more stringent than specified in (5) below if either of the following conditions are met:

(A) the current policy or certificate converts nursing home care only and the policy or certificate holder is converting to a Partnership Nursing Facility and Residential Care Facility Only Policy or Certificate with a lifetime maximum benefit that is no greater than the lifetime maximum benefit of the current policy or certificate; or

(B) the current policy or certificate covers home and community-based care and nursing home benefits and the policy or certificate holder is converting to a Partnership Comprehensive Policy or Certificate with a lifetime maximum benefit no greater than the lifetime maximum benefit of the current policy or certificate.

(5) Participating Issuers shall allow current policy or certificate holders who meet the conditions of (4) above to convert to a Partnership Policy or Certificate based on either no underwriting or underwriting that only disqualifies the policy or certificate holder from converting to a Partnership Policy or Certificate if he or she is:

(A) currently in benefit status or satisfying an elimination period; and/or

(B) currently receiving Formal or Informal Long-Term Care Services which would reasonably indicate that the policy or certificate holder would meet or shortly meet (within 1 year) the Insured Event criteria were the policy or certificate holder to be assessed; and/or

(C) currently using ambulation devices or medical equipment that would reasonably indicate that the policy or certificate holder would meet or shortly meet (within 1 year) the Insured Event criteria were he or she to be assessed.

(6) When a participating Issuer replaces the current policy or certificate of its policy or certificate holder with a Partnership Policy or Certificate, the Issuer shall acknowledge the prior coverage by granting a premium credit for each full year the original policy or certificate was in force toward all subsequent premium payments for the replacement Policy or Certificate as specified in Section 58066(b).

(b) Conversion of Partnership Policies and Certificates to Non-Partnership Status. The prospective Issuer of a non-Partnership policy or certificate to a holder of a current Partnership Policy or Certificate shall require the applicant to sign a form stating that he/she recognizes that the new policy or certificate does not conform to certification standards and that the Medi-Cal Property Exemption feature will no longer apply. This provision shall apply regardless of whether the original Partnership Policy or Certificate was issued by the Issuer of the new non-Partnership policy or certificate.

(c) Conversion of Non-tax-qualified Partnership Policies or Certificates to Tax Qualified Partnership Policies or Certificate.

Each participating Issuer which sold Non-tax qualified Partnership long-term care insurance Policies or Certificates after January 1, 1997 shall make the following provision for its policy or certificate holders:

(1) Notify each Policy or Certificate holder of the availability of a Tax-Qualified Partnership Policy or Certificate within ninety (90) days after such a Policy of Certificate first becomes available; and

(2) Allow each Policy or Certificate holder a minimum window of at least sixty (60) days to convert to a Tax-Qualified Partnership Policy or Certificate with similar coverage, a premium based on original issue age, and without new underwriting.

58054. Conversion of Certified Policies and Certificates to Non-Certified Status.

58055. Issuer's Liability.

Issuers of Partnership Policies or Certificates approved by the California Partnership for Long-Term Care shall be held liable for intentional or fraudulent material misrepresentation made by any agent, broker, solicitor, or Issuer representative regarding any feature or benefit of a Partnership Policy or Certificate that causes financial harm to the Policy or Certificate holder. In addition to any other applicable requirements of California Insurance Code, the Issuer shall be liable for the difference between the benefit promised by the agent,

broker, solicitor, or other Issuer representative and the actual benefit provided under the Policy or Certificate. The liability of Issuers shall not diminish or otherwise mitigate the statutory obligations and liabilities of licensed agents and brokers, solicitors, or other Issuer representatives.

58056. Agent Training.

(a) Issuers shall provide written evidence to the Department of Insurance that procedures are in place to assure that no agent, broker, solicitor, or individual will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a Partnership Long-Term Care Insurance Policy or Certificate unless the agent, broker, solicitor, or individual has completed eight (8) hours of education on long-term care in general that meet the requirements of Section 10234.93, Chapter 2.6 of Part 2 of the Insurance Code and eight (8) hours of training in a live classroom setting on the California Partnership for Long-Term Care in particular. Such assurances shall be in the form of a document signed by the agent, broker, solicitor, or individual and a representative of the company attesting to the completion of the required training by the agent, broker, solicitor, or individual and submitted to the Department of Insurance.

(b) Issuers shall provide written evidence to the Department of Insurance that procedures are in place to assure that no agent, broker, solicitor, or individual will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a Partnership Long-Term Care Insurance Policy or Certificate unless, prior to each license renewal, the agent, broker, solicitor, or individual completes eight (8) hours of education in a live classroom setting on the California Partnership for Long-Term Care. This educational requirement is in addition to the requirements of Section 10234.93, Chapter 2.6 of Part 2 of the Insurance Code, which the agent must complete prior to taking the 8 hour training on the California Partnership for Long-Term Care. For licensees issued a license after January 1, 1992, the Partnership education requirement shall be met by completing four (4) hours of such education in each licensure year. Assurances that the education requirements have been met shall be in the form of a document signed by the agent, broker, solicitor, or individual and a representative of the company attesting to the completion of the required training by the agent, broker, solicitor, or individual and submitted to the Department of Insurance.

(c) Issuers shall use only curriculum and instructors approved by the Department of Insurance and the California Partnership for Long-Term Care.

(d) The curriculum for training courses on the California Partnership for Long-Term Care used for continuing education shall be submitted for approval to the Department of Insurance and to the California Partnership for Long-Term Care on an annual basis no later than January 1.

(e) Issuers that are self-funded and not otherwise subject to compliance with the California Insurance Code shall be exempt from the

reporting requirements of this Section. Self-funded Issuers shall submit to the California Partnership for Long-Term Care written evidence that individuals authorized to market, sell, solicit, or otherwise contact persons for the purpose of marketing Certified Policies or Certificates have completed training equivalent to the requirements of this Section. Self-funded Issuers shall also use only curriculum and instructors approved by the California Partnership for Long-Term Care.

58057. Termination of Issuer Participation.

(a) Approval of the long-term care Partnership Policy or Certificate of each Issuer is conditional upon the Issuer fully complying with all requirements of this Chapter. The Director of the Department of Health Services may disqualify any Issuer from participation in the California Partnership for Long-Term Care, and may remove the approval status of any Partnership Policy or Certificate issued by an Issuer, whenever the Issuer fails to comply with any and all requirements of this Chapter.

(b) Any disqualification of an Issuer from participation in the California Partnership for Long-Term Care, or the removal of the certification of any Partnership Policy or Certificate, shall be after notice and hearing conducted in accordance with Chapter 5, Part 1, Division 3, Title 2 of the Government Code (sections 11500 et seq.).

(c) The Director may temporarily suspend any Issuer from participation in the California Partnership for Long-Term Care prior to a hearing when there is a substantial probability that federal financial participation will be adversely impacted by the Department's continued certification of the Issuer's Policy or Certificate or by the Issuer's continued participation in the California Partnership for Long-Term Care, or where the activities of the participating Issuer are either detrimental to the public interest or adversely impact other participating Issuers, Partnership Policy or Certificate holders, or the California Partnership for Long-Term Care. The Director shall notify the Issuer of any temporary suspension, and the effective date thereof, and at the same time shall serve the Issuer with a written description of the basis for the suspension. Upon the receipt of a notice of defense from the Issuer, the Director shall set the matter for hearing within 30 days after receipt of such notice. The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination on the merits. The temporary suspension shall be deemed vacated if the Director fails to make a determination on the merits within 60 days after the hearing was completed.

(d) If the Department of Health Services withdraws from the California Partnership for Long-Term Care or removes the certification status of any long-term care insurance Policy or Certificate, a Policy or Certificate holder who purchased a Policy or Certificate while the Policy or Certificate was certified will retain his or her right to the Medi-Cal Property Exemption. An individual who applies for any policy or certificate after the removal of certification status will have no right to the Medi-Cal Property Exemption.

(e) Any Issuer whose approval to market Partnership Policies or Certificates is removed by the Director or any issuer who discontinues selling a Partnership-approved Policy or Certificate, shall continue to comply with all requirements of this Chapter including the documentation and reporting requirements set forth in Article 6.

58058. Conditions Governing Discontinuance of Sales by the Issuer.

Pursuant to the authority granted by Welfare and Institutions Code Section 22005(e) and Insurance Code Section 12921, the following shall apply:
(a) No Partnership Long-Term Care Insurance Policy or Certificate shall be sold, transferred, or otherwise ceded to another Issuer without first having obtained approval from the Commissioner of the Department of Insurance.

(b) The Commissioner of the Department of Insurance shall not approve any sale, transfer, or ceding of any Partnership Long-Term Care Insurance Policy or Certificate if such action would result in premium increases for either the transferred Policy or Certificate holders or the Partnership Policies or Certificates that were not transferred, unless the Commissioner determines such a sale, transfer, or ceding to be in the public interest. The provision does not apply to:

(1) any reinsurance agreement or transaction in which the ceding Issuer continues to remain directly liable for its insurance obligations or risks under the contracts of insurance subject to the reinsurance agreement; and

(2) the ceding Issuer remains responsible for complying with all requirements of this Chapter and those imposed by Insurance Code Sections 1070 et seq. and 1090 et seq.

(c) Self-funded Issuers not subject to compliance with the California Insurance Code are exempt from the requirements of this Section.

58059. Required Benefits for Partnership Policies and Certificates.

No long-term care insurance policy or certificate may be approved, advertised, or solicited, in this state as a Partnership Long-Term Care Insurance Policy or Certificate which does not meet the standards of Article 3, and which has not been certified by the Department of Health Services and approved by the Commissioner of the Department of Insurance as a Partnership Long-Term Care Insurance Policy or Certificate. A Partnership Long-Term Care Insurance Policy or Certificate shall contain the following benefits and features:
(a) coverage for either nursing facility and Residential Care Facility only, or Comprehensive Benefits. Policies or Certificates covering only nursing facility and Residential Care Facility benefits shall display prominently on page one (1) of the Policy or Certificate:

"NURSING FACILITY AND RESIDENTIAL CARE FACILITY ONLY" POLICY [CERTIFICATE]

Policies or Certificates covering Nursing Facility, Residential Care Facility, and home and community-based benefits shall display prominently on page one (1) of the Policy or Certificate:

"COMPREHENSIVE" POLICY [CERTIFICATE]

(b) a lifetime maximum benefit that is set in dollars and not in days or other units of care;

(c) a lifetime maximum benefit which at the time of purchase is equivalent in dollars to at least three hundred sixty-five (365) times seventy percent (70%) of the Average Daily Private Pay Rate for Nursing Facilities;

(d) if a Partnership Nursing Facility and Residential Care Facility Only Policy or Certificate, it shall provide a Residential Care Facility as well as a nursing facility benefit;

(e) if a Partnership Comprehensive Benefits Policy or Certificate, it shall provide a Respite Care, a Residential Care Facility, and a Nursing Facility Benefit as well as the following home and community-based care benefits:

(1) Home Health Care;

(2) Adult Day Health/Social Care;

(3) Personal Care Services;

(4) Homemaker Services; and

(5) Hospice Care.

The definitions of these services must be identical to those contained in Article 1, and must appear verbatim in any Partnership Policy or Certificate.

(f) Care Management services by a Care Management Provider Agency. Changes for the initial assessment and individualized Plan of Care provided by a Care Management Provider Agency shall not be considered as a claim cost. Charges for coordinating the provision of care and monitoring services can be considered as a claim cost. Insurance benefit payments can count toward the Medi-Cal Property Exemption to the extent they are for Long-Term Care Services Countable Toward Medi-Cal Property Exemption delivered to insured individuals and are part of an individualized Plan of Care approved by the State-approved Care Management Provider Agency as the result of a face-to-face assessment

conducted by the Care Management Provider Agency (or its Qualified Official Designee).

(g) the Benefit Eligibility definition (appropriate for the type of Policy or Certificate), and the related definitions for Activities of Daily Living, Severe Cognitive Impairment, Hands-on Assistance, Standby Assistance, Substantial Supervision, Licensed Health Care Practitioner, Plan of Care, and Qualified Long-Term Care Services used to determine eligibility for benefits and when benefits begin counting toward the Medi-Cal Property Exemption. These definitions must be identical to those contained in Article 1, and must appear verbatim in any Partnership Policy or Certificate, except that policies or certificates issued by Issuers that are self-funded and not otherwise subject to compliance with the California Insurance Code may use in a Partnership Policy or Certificate different criteria for determining eligibility for policy benefits so long as the Policy or Certificate complies with the requirements of Section 7702B of the Internal Revenue Code, and so long as the criteria used are approved by the Department of Health Services.

(1) The Partnership will prescribe or approve the precise instruments to be used to determine if a Policy or Certificate holder has met the Benefit Eligibility definition. The Mental Status Questionnaire (MSQ), and the Folstein Mini Mental State Examination will be used to assess Severe Cognitive Impairment. Policy and Certificate holders will be deemed to have met the Severe Cognitive Impairment criteria for the Benefit Eligibility by:

(A) failing to answer correctly at least seven of the ten questions on the MSQ test; or,

(B) exhibiting specific behavior problems requiring daily supervision, including but not limited to wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others, and extreme or bizarre personal hygiene habits, and failing to answer correctly at least four questions on the MSQ, or achieving a score of 23 or lower on the Folstein Mini Mental State Examination.

(2) To determine Benefit Eligibility based on Activities of Daily Living,

(A) In a Comprehensive Policy or Certificate 2 Activities of Daily Living shall be used for home and community-based and Residential Care Facility benefits and either 2 or 3 Activities of Daily Living shall be used for the Nursing Facility benefit.

(B) In a Nursing Facility and Residential Care Facility Only Policy or Certificate, either 2 or 3 Activities of Daily Living shall be used.

(h) either the Elimination Period definition contained in Section 58010(a) must appear verbatim, or the definition specified in Section 58010(b) which defines the number of days the insured must be disabled before the benefits are covered by the Policy or Certificate, must be used in any Partnership Policy or Certificate. The Elimination Period shall not be less than thirty days (30) for Partnership Policies and Certificates with lifetime maximum benefits which at time of purchase are equivalent in dollars to less than seven hundred and thirty (730) times the Average Daily Private Pay Rate for Nursing Facilities. An Elimination Period of not more than ninety days (90) shall be used in Partnership Policies and Certificates with lifetime maximum benefits which at time of purchase are equivalent in dollars to at least seven hundred and thirty (730) times the Average Daily Private Pay Rate for Nursing Facilities;

(i) upon the issue date, if issued as an expense reimbursable Policy;

(1) a nursing facility per diem benefit of no less than seventy percent (70%) of the Average Daily Private Pay Rate for Nursing Facilities, rounded to the nearest multiple of ten dollars ($10);

(2) a Residential Care Facility benefit that is not less than seventy percent (70%) and not more than one hundred percent (100%) of the nursing facility per diem benefit contained in the Partnership Policy or Certificate;

(3) a Respite Care Benefit in Policies or Certificates with Comprehensive Benefits that is not subject to the Elimination Period and not less than a total of 21 days in any calendar year for care in a Nursing Facility, Residential Care Facility, or in a home or a community-based program. The Respite Care benefit is payable at the daily and monthly maximum benefit amounts applicable for the type of service being used to provide the Respite Care; and

(4) monthly home and community-based care benefits, for Partnership Policies or Certificates with Comprehensive Benefits, of at least fifty percent (50%) and no more than one hundred (100%) of the nursing facility per diem benefit provided in the Partnership Policy or Certificate, multiplied by thirty. The home and community-based care benefits shall be issued in increments of ten percent (10%). Insurance products approved for residents in continuing care retirement communities are exempt from this provision;

(j) upon the issue date, if issued on an expense incurred basis, benefits that pay no less than seventy percent (70%) and no more than one hundred (100%) of the cost incurred by the insured for all covered services;

(k) an inflation protection provision which satisfies one (1) of the following criteria:

(1) if the Partnership Policy or Certificate is issued on an expense incurred basis, as specified in Section 58059(j), the lifetime

maximum benefit must automatically increase at five percent (5%) each year over the previous year for each year that the contract is in force with the following exception: the Partnership Policy or Certificate may be issued with a lifetime maximum benefit that automatically increases each year by a fixed amount equal to five percent (5%) of the original amount issued provided that the applicant is seventy (70) years of age or over at the time the application is taken, the applicant is first offered an inflation protection provision that automatically increases by five percent (5%) each year over the previous year for each year that the contract is in force, and the applicant is given a graph which illustrates the difference in policy benefits payable between the two inflation protection provisions and the cost of care; or

(2) if the Partnership Policy or Certificate is issued on an expense reimbursable basis, the nursing facility per diem benefit, the lifetime maximum benefit, and the monthly home and community-based care benefit if a Comprehensive Benefits Policy or Certificate, must automatically increase at five percent (5%) each year over the previous year for each year that the contract is in force, with the following exception: the Partnership Policy or Certificate may be issued with a nursing facility per diem benefit, a lifetime maximum benefit, and a monthly home and community-based care benefit if a Comprehensive Benefits Policy or Certificate, that automatically increases by five percent (5%) each year over the amount initially issued provided that the applicant is seventy (70) years of age or over at the time the application is taken, the applicant is first offered an inflation protection provision that automatically increases by five percent (5%) each year over the previous year for each year that the contract is in force, and the applicant is given a graph which illustrates the difference in policy benefits payable between the two inflation protection provisions;

(l) a Shortened Benefit Period Non-Forfeiture Benefit, or a provision that gives the Policy or Certificate holder the option to elect, at the time the Partnership Policy or Certificate is issued, to pay an extra premium for a rider providing such a benefit. The Shortened Benefit Period Non-Forfeiture Benefit must have the following features:

(1) eligibility begins no later than after ten (10) years of premium payments;

(2) the lifetime maximum benefit is no less than the dollar equivalent of three (3) months of care at the nursing facility per diem benefit contained in the Partnership Policy or Certificate and, in the case of an expense reimbursable Policy or Certificate, the nursing facility per diem and monthly home and community-based care benefit, if a Comprehensive Benefits Policy or Certificate, are no less than the benefits already contained in the Policy or Certificate.

(3) the lifetime maximum benefit, and, in the case of an expense reimbursable Policy or Certificate, the nursing facility per diem

benefit, and the monthly home and community care benefit if a Comprehensive Benefits Policy or Certificate, increases each year in the same amount and is computed in the same manner as the inflation protection provision issued with the Policy or Certificate as specified in subsection (k) of this section;

(4) the lifetime maximum benefit may be reduced by the amount of any claims already paid;

(5) Cash back, extended term, and reduced paid-up forms of non-forfeiture benefits will not be allowed. Other non-forfeiture benefits that meet the requirements of this Section may be allowed if they are acceptable to the Department of Health Services and the Department of Insurance.

(m) Self-funded Issuers not subject to California Insurance Code are exempt from:

(1) the requirement of Subsection (e) that the definition for Homemaker Services be used verbatim in each Comprehensive Policy and Certificate as long as the definition conforms to Section 58017; and

(2) the requirement of Subsection (i)(2) to include a Residential Care Facility Benefit that is no less than seventy percent (70%) of the nursing facility per diem benefit contained in the Partnership Policy or Certificate, as long as a Residential Care Facility Benefit is included at no less than fifty percent (50%) of the nursing facility per diem benefit contained in the Partnership Policy or Certificate.

58060. Required Provisions for Partnership Policies and Certificates.

Partnership Long Term Care Policies or Certificates shall contain the following provisions:
(a) a provision that benefits may not be paid in excess of actual charges.

(b) a provision that the long-term care services covered by the Partnership Policy or Certificate may not be delivered by a member of the individual's family, unless:

(1) the family member is a regular employee of an organization which is providing the services; and

(2) the organization receives the payment for the services; and

(3) the family member receives no compensation other than the normal compensation for employees in his or her job category.

(c) a provision to protect against unintentional lapse that provides the following:

(1) No individual long-term care Policy or Certificate shall be issued until the Issuer has received from the applicant either of the following:

(A) A written designation of at least one Authorized Designee, in addition to the applicant, who is to receive notice of lapse or termination of the Policy or Certificate for nonpayment of premium.

(B) A written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

(2) The applicant has the right to designate at least one Authorized Designee who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one Authorized Designee. The designation shall include each Authorized Designee's full name and home address. The Issuer shall notify the insured of the right to change this written designation, no less often than once every two years. In the case of an applicant who elects not to designate an additional person, the waiver shall state:

"Protection Against Unintended Lapse.

I understand that I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive this notice."

(3) When the Policy or Certificate holder pays the premium for a Partnership Long-Term Care Insurance Policy or Certificate through a payroll or pension deduction plan, the requirements contained in paragraph (1) need not be met until 60 days after the Policy or Certificate holder is no longer on that deduction payment plan. The application or enrollment form for a Partnership Long-Term Care Insurance Policy or Certificate shall clearly indicate the deduction payment plan selected by the applicant.

(4) No individual long-term care Policy or Certificate shall lapse or be terminated for nonpayment of premium unless the Issuer, at

least 30 days prior to the effective date of the lapse or termination, gives notice to the insured and to those Authorized Designees named pursuant to paragraph (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, no less than 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(5) In addition to the requirement in Subsection (c)(1), a Partnership Long-Term Care Insurance Policy or Certificate shall include a provision which, in the event of lapse, provides for reinstatement of coverage, if the Issuer is provided with proof of the insured's Cognitive Impairment or loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of Severe Cognitive Impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on Severe Cognitive Impairment or the loss of functional capacity contained in the Policy or Certificate.

(d) a provision that benefits shall only be paid after the payment of all other benefits to which the Policy or Certificate holder is otherwise entitled, excluding Medi-Cal. The Issuer shall make reasonable efforts to determine whether benefits are available from other policies or certificates or from Medicare. Benefits are not payable for Medicare co-payments and deductibles.

(e) a statement on the outline of coverage, the Policy or Certificate application, and the Policy or Certificate in bold type and in a separate box as follows:

"THE BENEFITS PAYABLE BY THIS POLICY [CERTIFICATE] QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE.

ELIGIBILITY FOR MEDI-CAL IS NOT AUTOMATIC. IF AND WHEN YOU NEED MEDI-CAL, YOU MUST APPLY AND MEET THE ASSET STANDARDS IN EFFECT AT THAT TIME. UPON BECOMING A MEDI-CAL BENEFICIARY, YOU WILL BE ELIGIBLE FOR ALL MEDICALLY NECESSARY BENEFITS MEDI-CAL PROVIDES AT THAT TIME, BUT YOU MAY NEED TO APPLY A PORTION OF YOUR INCOME TOWARD THE COST OF YOUR CARE. MEDI-CAL SERVICES MAY BE DIFFERENT THAN THE SERVICES RECEIVED UNDER THE PRIVATE INSURANCE.

(f) a provision that, in the event a non-Medicaid national or State long-term care program is created through public funding that substantially duplicates benefits covered by Partnership Policies or Certificates, the Policy or Certificate holder will be entitled to be compensated as follows:

(1) for Policies or Certificates issued before January 1, 1997, or for Policies or Certificates issued after January 1, 1997 that are not federally tax-qualified, the Policy or Certificate holder will be entitled to select either a partial refund of premiums paid or a reduction in future premiums. An actuarial method for determining the premium refunds and premium reductions will be mutually agreed upon by the Department of Insurance and the Issuers. The amount of the premium

refunds and reductions to be made by each Issuer will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and claims experience. Each participating Issuer's premium refund and reduction plans shall be filed and approved by the Department of Insurance.

(2) for Policies or Certificates issued after January 1, 1997, that are federally tax-qualified, the Policy or Certificate holder will be entitled to select either a reduction in future premiums or an increase in future benefits. An actuarial method for determining the premium reductions and increases in future benefits will be mutually agreed upon by the Department of Insurance and the Issuers. The amount of the premium reductions and benefit increases to be made by each Issuer will be based on the extent of the duplication of covered benefits, the amount of past premium payments and claims experience. Each participating Issuer's premium reduction and benefit increase plans shall be filed and approved by the Department of Justice.

(g) a provision for a waiver of premium as specified in Section 58065(d).

58061. Required Provisions to Allow the Increase or Decrease of Benefits in Partnership Policies or Certificates.

Partnership Long-Term Care Insurance Policies or Certificates shall contain:
(a) a provision that gives the Policy or Certificate holder the option to elect, no less frequently than on each anniversary date after the Policy or Certificate is issued, to pay an extra premium for one or all of the following three riders:
(1) a rider for a Nursing Facility and Residential Care Facility Only expense reimbursable Policy or Certificate to increase the amount of the nursing facility per diem benefit, so long as the increase in the per diem amount is issued in multiples of ten (10) in ten dollar ($10) increments;

(2) a rider for a Comprehensive Benefit expense reimbursable Policy or Certificate to increase the amount of the nursing facility per diem and the monthly home and community-based care benefit, so long as the increase in the nursing facility per diem amount is issued in multiples of ten (10) in ten dollar ($10) increments and the monthly home and community-based care benefit is issued in multiples of ten (10) and in the same ratio to the nursing facility per diem as the ratio in the original Policy or Certificate;

(3) a rider for an expense reimbursable or expense incurred Policy or Certificate to increase the lifetime maximum benefit of

either a Nursing Facility and Residential Care Facility Only or a Comprehensive Benefits Policy or Certificate.

The Issuer may require the Policy or Certificate holder to undergo new underwriting, in addition to the payment of an additional premium, to qualify for the rider(s) elected. The Issuer may restrict the aggregate amount of additional coverage a Policy or Certificate holder may acquire by rider(s) to the maximum coverage allowed by this Section or the maximum the Issuer allows when issuing a new Partnership Policy or Certificate, whichever is less. The Issuer may use the same age restrictions for the issuance of any rider governed by this section as the age limits, if any, that the Issuer uses for the issuance or delivery of a new Partnership Policy or Certificate. The extra premium for the increased coverages elected by the Policy or Certificate holder shall be calculated in accordance with Section 58066(a).

(b) a provision that, in the event the Issuer develops new benefits and/or provisions not included in its original Partnership Policy or Certificate or markets a replacement Policy, the Issuer will grant current holders of its Partnership Policies or Certificates who are not in benefit or within the Elimination Period the following rights:

(1) they will be notified by the Issuer of the availability of the new benefits and/or provisions within twelve months;

(2) they will be afforded an opportunity by the Issuer to acquire the new benefits and/or provisions in one of the following ways:

(A) by adding a rider to the original Partnership Policy or Certificate, in which case a separate premium will be calculated for the rider based on the Policy or Certificate holder's attained age; the premium for the original Policy or Certificate will remain unchanged based on age at issuance;

(B) by replacing their existing Partnership Policy or Certificate with a subsequent Partnership Policy or Certificate issued by the current Issuer, in which case consideration for past insured status shall be recognized by giving a five percent (5%) premium credit for each full year the original Partnership Policy or Certificate was in force toward all subsequent premium payments for the replacement Partnership Policy or Certificate as specified in Section 58066(b);

(C) by replacing their existing Partnership Policy or Certificate with a subsequent Partnership Policy or Certificate with a premium based on the insured's original issue age.

(3) they may have to undergo new underwriting, but the underwriting can be no more restrictive than if the Policy or Certificate holder were applying for a new Partnership Policy or Certificate.

(4) the Issuer of Partnership group Policies must offer current group Policy holders the opportunity to have the new benefits and/or provisions extended to current Certificate holders, but the Issuer is relieved of the obligations imposed by this provision if the holder of the group Policy declines the Issuer's offer.

(c) a provision that gives the Policy or Certificate holder a right, exercisable any time after the first year, to retain a Policy or Certificate meeting all the requirements of certification while lowering the premium subject to the following conditions:

(1) the Policy or Certificate holder of an expense reimbursable Policy or Certificate may:

(A) reduce the nursing facility per diem and the monthly home and community-based care benefit (but not below the minimum specified in Section 58050(a) or (b)), and/or;

(B) reduce the lifetime maximum benefit, but not below the dollar equivalent of one hundred eight-two (182) times seventy percent (70%) of the Average Daily Private Pay Rate for Nursing Facilities;

(2) the Policy or Certificate holder of an expense incurred Policy may;

(A) reduce the lifetime maximum benefit, but not below the dollar equivalent of one hundred eight-two (182) times seventy percent (70%) of the Average Daily Private Pay Rate for Nursing Facilities;

(3) the Policy or Certificate holder of either an expense reimbursable or expense incurred Comprehensive Benefits Policy or Certificate may convert to a Nursing Facility and Residential Care Facility Only Policy or Certificate with per diem not less than the minimums specified in Section 58050(b) and a lifetime maximum benefit no less than the dollar equivalent of one hundred eight-two (182) times seventy percent (70%) of the Average Daily Private Pay Rate for Nursing Facilities;

(4) the reduced nursing facility per diem benefit, lifetime maximum benefit, and, if a Comprehensive Benefits Policy or Certificate, monthly home and community-based care benefit, of an expense reimbursable Policy or Certificate, must increase each year in the same amount and be computed in the same manner as the inflation protection provision issued with the original Policy or Certificate as specified in subsection (k) of Section 58059;

(5) the lower premium for any reduced coverage Policy or Certificate shall be calculated in accordance with 58066(c);

(6) in the event a Policy or Certificate is about to lapse, the Issuer shall advise the Policy or Certificate holder of the options to lower the premium by reducing coverage and of the premiums, applicable to the reduced coverage; if the Policy or Certificate has a Non-Forfeiture Benefit rider, the Issuer shall also advise the Policy or Certificate holder that the the original policy may be kept in force for a shortened benefit period under the Non-Forfeiture Benefit rider.

58062. Benefits and Provisions Allowable in Partnership Policies or Certificates.

Issuers are allowed to include the following optional benefits and provisions in Partnership Long-Term Care Policies and Certificates;
(a) additional benefits over the minimum benefits required in Comprehensive Benefit Policies or Certificates by Section 58059(e), so long as these benefits are for Long-Term Care Services Countable Toward the Medi-Cal Property Exemption.

(b) a provision to prorate home and community-based care benefits based on the percentage of the month a Policy or Certificate holder was eligible for benefits.

(c) a provision in expense reimbursable Policies and Certificates that requires Policy or Certificate holders to pay co-payments, not to exceed twenty percent (20%), toward the cost of any home and community-based care benefits received in one day that exceed $50.

(d) the use of a Preferred Provider Organization (PPO) to deliver covered benefits and/or the use of a Point-of-Service reimbursement schedule that provides different reimbursement rates for Policy or Certificate holders who go out-of-plan to receive covered benefits, provided that the reimbursement rates at least meet the minimum benefits specified in Section 58050.

(e) a provision that institutional and home and community-based care benefits need not be paid on the same day.

58063. Prohibited Provisions in Partnership Policies or Certificates.

The following provisions may not be included in a Partnership Policy or Certificate:
(a) a restoration of benefits;

(b) a second Elimination Period;

(c) any cap on the daily or weekly (as opposed to monthly) home and community-based care benefits.

58064. Information for Establishing Allowable Benefits and Minimum and Maximum Benefits.

The Department of Health Services shall distribute the following to assist in implementing the requirements of this Chapter.
(a) a Long Term Care Issuer's Bulletin to participating Issuers. This Long Term Care Issuer's Bulletin, to be issued in November of each year, will establish the Average Daily Private Pay Rate for Nursing Facilities for the upcoming calendar year and establish the minimum benefits that may be covered in all Partnership Policies and Certificates issued or delivered in the upcoming calendar year; and,

(b) a list of Long-Term Care Services Countable Toward the Medi-Cal Property Exemption as identified in Section 58003.

58065. Basic Premium Provisions.

(a) The initial premiums for Partnership Policies and Certificates issued or delivered shall either:
(1) remain level for the life of the Policy or Certificate; or,

(2) increase annually at the rate of no more than five percent (5%) for each year the Partnership Policy or Certificate is in force, in order to provide inflation protection.

(b) The initial premiums for all Partnership Policies and Certificates, whether such Policies or Certificates were issued or delivered with premiums that remain level for the life of the Policy or Certificate or that increase annually at a rate no more than of five percent (5), shall be:
(1) based on the age of the applicant; and,

(2) based on premium rates for which there is a reasonable expectation that rate increases will not be necessary in the future. The Department of Health Services shall not certify a Policy or Certificate and the Department of Insurance shall not approve the premium rates unless a determination is made, based on a review of the Insurer's rate experience with prior offerings, financial condition, and an actuarial review of the rates and assumptions by the Department of Insurance, that there is a reasonable expectation that no rate increase on the Policy or Certificate will be necessary over the life of the Policy or Certificate.

(c) The actuarial filings and premium schedules for indemnity Policies and Certificates shall be presented in units of ten dollars ($10).

(d) The premium for the original Partnership Policy or Certificate as well as any optional rider(s) in force shall be waived during all periods during which the Policy or Certificate holder is receiving nursing facility or Residential Care Facility benefits under the Policy or Certificate. Issuers may elect to waive premiums when home and community-based care services are received.

(e) Any Issuer offering a guarantee of premium on a long-term care Policy or Certificate must offer the guarantee for a period of no less than ten (10) years.

(f) Nothing in this subdivision shall preclude an Issuer from reducing premiums or using a Policy form or Certificate form in which the premiums are no longer required to be paid after a specified period of time.

(g) Self-funded Issuers not subject to compliance with the California Insurance Code are exempt from the requirements of Subsection (b)(2), above.

58066. Provisions Governing Premiums When Benefits Increase or Decrease.

(a) The extra premiums for the optional rider(s) that add a Shortened Benefit Period Non-Forfeiture Benefit described in Section 58059(l) and/or that increase the amounts of the covered benefits of the Policy or Certificate as provided in Section 58061(a)(1)(2) and (3) shall be in the same form as the original Policy -either remain level for the life of the Policy or increase annually at no more than five percent (5%). The extra premiums for the optional rider(s) may be based on the attained age of the Policy or Certificate holder at the time the rider is elected. Premiums for the optional riders shall be filed and approved by the Department of Insurance at the time rates are filed initially. For the optional riders allowed in Section 58061(a)(1) and (2), the premiums for each additional $10 unit of a covered benefit shall be the rate that corresponds to the current attained age of the Policy or Certificate holder as such rates were filed initially and approved by the Department of Insurance. For the optional riders allowed in Section 58061(a)(3), the premium for the increase in the lifetime maximum benefit shall be the difference in premiums between the new lifetime maximum benefit elected and the lifetime maximum benefit of the current Policy or Certificate, based on the rates filed initially and approved by the Department of Insurance and the current attained age of the Policy or Certificate holder. The premium for the underlying coverage of the original Policy or Certificate shall not be changed by the addition of one or more riders and shall continue to be based on the age of the Policy or Certificate holder on the date when the original Policy or Certificate was issued or delivered.

(b) When an Issuer replaces a non-Partnership or a Partnership Policy or Certificate it has previously issued with either a new non-Partnership or Partnership Policy or Certificate, the Issuer shall

recognize past insured status by granting a premium credit that meets the requirements of Insurance Code 10234.87, and satisfies the following conditions:

(1) a credit equal to or not less than five percent (5%) of the premium for the original policy or certificate for each full year the original policy or certificate was in force shall be given toward all subsequent premium payments for the replacement policy or certificate. However, the cumulative credit allowed need not exceed fifty percent (50%).

(2) no credit need be provided if a claim has been filed under the original policy or certificate. The cumulative credits allowed need not reduce the premium for the replacement policy to less than the premium for the original policy or certificate. No credit need be provided if there is no difference between the premium for the replacement policy or certificate and the premium for the current policy or certificate.

(c) The premium when a Partnership Policy or Certificate holder elects to reduce the coverage of the original Policy or Certificate as provided in Section 58061(c)(1)(2) and (3) will be calculated as follows:

(1) the premium will be based on the reduced amount of coverage elected and the age of the Policy or Certificate holder at issue age; and

(2) the premium reductions from the change in coverage shall be applied toward all future premium payments.

(d) Self-funded Issuers not subject to compliance with the California Insurance Code are exempt from the requirements of Subsection (a), above, that premiums for the optional riders be submitted to and approved by the Department of Insurance.

58067. Provisions Governing Rate Increases.

(a) Participating Issuers in the California Partnership for Long-Term Care shall conduct annual actuarial reviews to determine how well current premiums are covering anticipated expenditures for Partnership Policies and Certificates. The result of these reviews shall be made available to the Department of Insurance in a manner and format prescribed by the Department.

(b) Increases in the premiums for all Policies or Certificates and all optional riders can only be made on a class basis after approval by the Department of Insurance. The Department of Insurance shall not approve any premium increases greater than a cumulative total of forty percent

(40%) over any three-year period; the total amount of any approved rate increase must be spread equally over each of the three years. This restriction may be waived by the Commissioner of the Department of Insurance in the event the Issuer demonstrates to the Commissioner's satisfaction that major unforeseen changes in the long-term care environment threaten the solvency of the plan or the company. Examples of such changes include a significant change by the courts in the interpretation of benefit or benefit eligibility language, or major medical breakthroughs which notably change underlying morbidity patterns.

(c) If a premium increase is approved by the Department of Insurance, the Issuer shall include in the premium increase notice to the Policy or Certificate holder, or by separate notice to the Certificate holder, a statement advising them of the options to lower their premiums by reducing coverage as provided in Section 58061(c).

(d) Self-funded Issuers not subject to compliance with the California Insurance Code are exempt from the requirement of Subsection (a), above, that the annual actuarial reviews be submitted to and conducted in a manner prescribed by the Department of Insurance and the requirement of Subsection (b), above, pertaining to the Department of Insurance's approval of all premium increases for Partnership Policies or Certificates and for all optional riders to Partnership Policies or Certificates.

58068. Care Management Provider Agency Functions.

(a) The Care Management Provider Agency must be capable of providing a professional assessment of a person's physical, cognitive, social and emotional functional levels in order to identify individual strengths and needs. The individual's current functional capacities, family and other support systems, financial status and living arrangements must be evaluated as well. The Care Management Provider Agency must be able to develop a comprehensive Plan of Care that addresses identified needs in a cost effective manner. When desired by the individual and determined necessary by the Care Management Provider Agency, the Care Management Provider Agency must be able to arrange for the delivery and coordination of services as well as monitor their quality over an extended period.

58069. The Role of the Care Management Supervisor.

(a) A Care Management Supervisor shall have demonstrated expert ability in the Care Management role. This individual shall also:

(1) support and clarify the role of the Care Manager;

(2) be accessible to Care Managers on a scheduled and as needed basis;

(3) provide guidance on decisions requiring judgment, assist with problem situations, and approve Plans of Care and discharge;

(4) demonstrate administrative ability to explain goals, policies, and procedures, and assist staff in adjusting to changes that occur;

(5) encourage the development of professional growth and upgrading of skill through access to training and current literature; and

(6) evaluate the Care Manager's performance based on established criteria. The evaluation shall include: a review of client records, observations of client visits, supervisory conferences, and productivity measures.

58070. Staff Qualifications.

(a) Care Managers shall meet or exceed both of the following qualifications:

(1) be a registered nurse and/or graduate of an accredited four year college or university with a degree in nursing, health, social work, gerontology or other related area; and

(2) have a minimum of two years of experience in the human service field, ideally in community-based care. A master's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

(b) If the Care Manager has a social service background, the agency will have nursing or clinical health care staff available for consultation; if the Care Manager has a clinical health care background, the agency shall have psycho/social staff available for consultation.

(c) All Care Management Supervisors shall, in addition to meeting Care Manager standards, have at least two years of Care Management experience.

58071. Staff Ratios.

(a) Care Management staffing ratios shall not exceed the following:

(1) clients to Care Manager: 60:1 (total clients in benefit status); and

(2) Care Managers to Care Management Supervisor: 10:1.

58072. Client Bill of Rights and Responsibilities.

(a) A Care Management Provider Agency shall have a written list of rights and legal responsibilities which shall be presented to each client or his or her representative at the time of assessment or as soon as possible thereafter. The list shall include:

(1) a description of available services, and unit charges and billing mechanisms (where applicable);

(2) a policy on which services are covered by the insurance benefit and which services need to be paid for out-of-pocket (where applicable);

(3) the criteria for admission to service and discharge from service;

(4) a right to be informed of the name of their Care Manager and of the manner in which that person may be contacted;

(5) a right for active client participation in the development and implementation of the Plan of Care. The client or officially designated representative shall, prior to implementation, receive a copy of the Plan of Care and a written list of all potential service providers to be involved in implementation of the Plan of Care;

(6) a right for the client or officially designated representative to be fully informed of the client's health condition;

(7) a provision for the confidential treatment of all client information retained by the agency and a requirement for written consent to release information to persons not otherwise authorized under law to receive it;

(8) a policy regarding client access to the case record;

(9) an explanation of the appeal procedure and the right to file an appeal of benefit eligibility or Plan of Care service authorization decisions without discrimination or reprisal from the agency;

(10) procedures for registering and resolving complaints; and

(11) a right to a discharge plan when the Care Management Provider Agency services are about to be terminated. If the Policy or Certificate holder is immediately eligible for Medi-Cal, the Care Management Provider Agency will prepare a transition plan. The transition plan and/or discharge plan must be provided to the Policy or Certificate holder within 30 days after receipt of notification from the Issuer that coverage will be exhausted.

58073. Quality Assurance.

(a) A Care Management Provider Agency shall have a written quality assurance program which shall include but not be limited to:

(1) Annual program evaluation. The agency's board of directors (or their appointed designees) shall, at least Annually, review policies and make recommendations on:

(A) admission and discharge criteria;

(B) Plans of Care and records;

(C) personnel qualifications;

(D) quality assurance program;

(E) delivery of Care Management services; and

(F) methods for assuring the quality of direct services provided including whether client needs as identified in the Plans of Care were met, assessing client satisfaction and incorporating client suggestions.

The written minutes of this annual program evaluation meeting shall document the dates of the meeting(s), attendance, agenda and recommendations.

(2) Quarterly service record review. At least Quarterly, the agency's board of directors, or a committee appointed by the board, shall, observing all confidentiality protocols, review a random sample of active and closed case records. Each record review shall be documented on a record review form and shall include, but not be limited to, verification that:

(A) agency policies are followed in the provision of services to clients and families;

(B) clients and families actively participate in the care planning process, including the decision regarding how much coordination and monitoring is necessary and desirable;

(C) client, family and other community resources are integrated into the Plan of Care;

(D) Care Management services are effective in maintaining an appropriate environment for the client;

(E) the provision of services is coordinated with those provided by other agencies to avoid duplication of services, and to integrate acute care with chronic care;

(F) action is initiated by the Care Management Provider Agency when unmet client service needs are identified. Pattern of unmet needs should be documented and reported to the Department of Health Services;

(G) the agency's sampling methodology shall be defined in its quality assurance program policies and procedures. The sample of client records reviewed each Quarter shall be according to the following ratios:

1. eighty (80) or less cases; eight (8) records; and

2. eighty-one (81) or more cases; ten percent (10%) of caseload for the Quarter to a maximum of twenty-five (25) records.

(3) Annual documentation of clinical competence. At least Annually, a written evaluation report shall be prepared on the clinical competence of each Care Manager by the employee's professional supervisor. Each Care Manager shall review and sign his/her evaluation report, a copy of which shall remain in the employee's personnel folder. The evaluation report shall include but not be limited to:

(A) coordination, assessment and monitoring skills (including clinical counseling, ability to elicit client input and act upon client feedback, problem solving, and ability to build rapport with clients, families and other providers);

(B) recording in client case records; and

(C) participation in the agency's in-service educational programs.

58074. Annual Report of the Agency's Quality Assurance Program.

(a) An Annual written report of the agency's quality assurance program shall be prepared and submitted to the governing authority. The report shall summarize all findings and recommendations resulting from the quality assurance activities. This report and documentation of all actions on the findings or recommendations shall be available to the contracting Issuer(s) and the Department of Health Services (DHS).

58075. Objectivity and Impartiality.

(a) To insure objectivity, the Care Management Provider Agencies which also provide other services included in an insured's Plan of Care will be required to document that clients were made aware of a full array of services, and the costs and availability of other providers of these services.

(b) Individuals who provide direct care as described in Section 58059(e) cannot also act as Care Managers for assessment and care planning.

(c) Direct service providers and Care Managers should not report to the same clinical supervisor.

(d) Employees of the Issuer cannot also act as Care Managers for assessment and care planning.

58076. Policy Manual.

(a) Prior to the Care Management Provider Agency being approved by the State, and with an Annual update thereafter, the Care Management Provider Agency must file the following with the Department of Health Services and with each Issuer with whom they contract:

(1) an organizational chart; and

(2) a policy manual that includes the following:

(A) job descriptions;

(B) Care Manager training requirements;

(C) Care Manager availability and turn-around time for conducting assessments and developing Plans of Care;

(D) personal policies;

(E) the appeals procedure;

(F) the client bill of rights and responsibilities as described in Section 58072;

(G) the agency's quality assurance program (including the Annual program evaluation, the Quarterly service record review and verification that the Annual documentation of clinical competence has been completed);

(H) data collection procedures (including confidentiality safeguards);

(I) records retention procedures; and

(J) documentation of efforts to provide culturally sensitive services.

58077. Issuer Reporting Requirements.

Unless otherwise noted, the requirements of this Section refer to Issuer documentation and reporting requirements for Partnership Policies and Certificates. Reports are due thirty (30) days after the close of reporting periods specified for the respective reports. Issuers shall submit the following reports, which are all part of the Long-Term Care Insurance Uniform Data Set.
(a) Report on new purchasers. Each Issuer shall maintain a registry of new purchasers and submit on a Quarterly basis aligned with the State Fiscal Year, a report to the Department of Health Services that will include the following information on all individuals who purchased a Partnership Policy or Certificate during the reporting period:
(1) name, address, telephone number, date of birth, sex, marital status, and Social Security number;

(2) Policy or Certificate identification information, including the following:

(A) Policy or Certificate form number;

(B) Policy or Certificate category (individual, organization-sponsored, or group);

(C) effective date of coverage;

(D) Policy type (Nursing Facility and Residential Care Facility Only; Comprehensive Benefit; Single Life; or Multi-Life);

(3) Policy or Certificate Elimination Period in days;

(4) the maximum daily benefit for nursing facility care and monthly benefit for home and community-based care;

(5) maximum lifetime benefit amount in dollars;

(6) any options and riders in force;

(7) purchase type (upgrade from non-Partnership policy or certificate of reporting company, conversion, replacement of another company's policy or certificate, or new issue);

(8) for expense-incurred Policies or Certificates, the percentage of expenses payable;

(9) the annual premium for the Policy or Certificate, the premium payment mode (also known as the "premium frequency"), and the type of premium (level, indexed, or lump sum); and

(10) the name and address of the Authorized Designee to be notified in the event that the Policy is in danger of lapsing due to unpaid premium.

(b) Report on persons who changed or dropped their Policies or Certificates. For the purposes of this Chapter, a Policy change shall include the following: upgrades, reduced coverage option, reinstatement, inflation upgrade, changes to benefits, riders, premium series rerate, Policy category changes, inflation catch-up, Social

Security number change, conversion to single/multi-life, non-forfeiture or partnership status lost. Each Issuer shall submit on a Quarterly basis aligned with the State Fiscal Year and in a format specified by the State of California, a report to the Department of Health Services that will include the following information on all individuals who have changed or dropped Partnership Policies or Certificates during the reporting period:

(1) name, address, telephone number, and Social Security number;

(2) effective date of original Policy which is reported in Section 58077(a)(2)(C);

(3) effective date of the Policy or Certificate change or drop;

(4) if applicable, a description of the new Policy or Certificate or amended Policy or Certificate as described in Section 58051(h);

(5) if applicable, the reason the Policy or Certificate was dropped, including any of the following:

(A) death of insured;

(B) converted Policy or Certificate;

(C) benefits exhausted;

(D) recision;

(E) voluntarily;

(F) certified status of the Policy or Certificate lost;

(G) other; and

(H) unknown.

(c) Report on persons who were assessed for long-term care benefit eligibility. Each Issuer shall submit on a Quarterly basis aligned with the State Fiscal Year and in a format specified by the State of California, a report to the Department of Health Services that will include the following information on all individuals who were assessed for long-term care benefit eligibility during the reporting period:

(1) name, address, telephone number, Social Security number, sex, marital status, and living arrangements (alone, with spouse, or with other relatives);

(2) Medicare status (Part A, Part A and B, or none);

(3) other insurance status (Medicare supplement, prepaid health care, or none);

(4) date the assessment was conducted;

(5) benefit contact;

(6) name, address, and telephone number of the person or company that performed the assessment and whether the claimant was found eligible for long-term care services and for Medi-Cal Property Exemption;

(7) eligibility decision date;

(8) effective date of disability; and

(9) a listing of the Benefit Eligibility criteria met for all persons assessed, including deficiencies in Activities of Daily Living, and Severe Cognitive Impairment.

(d) Report on service payments and utilization.

Each Issuer shall submit on a Quarterly basis aligned with the State Fiscal Year and in a format specified by the State of California, a report (in the event the payment is for a service received during a prior reporting period, a separate record shall be generated for each quarter during which a service was received) to the Department of Health Services that will include the following information on the services or benefits paid each month during the reporting period for each insured person:

(1) name and Social Security number of the beneficiary;

(2) Policy or Certificate identification information, including the following:

(A) the Policy or Certificate form number;

(B) the original effective date of coverage;

(3) service code;

(4) number of units of service delivered during the reporting period;

(5) the last month of the quarter in which the reported services were delivered;

(6) the dollar amount of services or benefits paid by the Policy or Certificate and the amount paid that counts toward the Medi-Cal Property Exemption (Asset Protection);

(7) the number of units of service paid by the Policy or Certificate during the reporting period;

(8) the total number of days of service paid for by the Policy or Certificate during the reporting period for services received.

(9) remaining benefit (in dollars) that indicates the total remaining benefit at the end of the reporting period;

(10) remaining nursing home benefit (in days);

(11) remaining home care benefit (in days).

(e) Report on applications received, denied and total Policies in force at end of the reporting period.

Each Issuer shall report on a quarterly basis and in a format specified by the State of California, a single entry summary count of:

(1) the total number of applications received at the Insurer's office during the reporting period.

(2) the total number of applications denied during the reporting period.

(3) the total number of Policies in force at the end of the reporting period.

(f) Issuers will respond to all errors within 30 days of receipt of notification from the Department of a file and/or data error.

58078. Records Maintenance.

(a) Each Issuer shall maintain information as stipulated in subsection (f) on all Policy or Certificate holders who have ever received any benefit under the Policy or Certificate. Such information shall be updated at least Quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the Policy or Certificate holder's condition which is not otherwise required by federal or State statute or regulation.

(b) When a Policy or Certificate holder who has received any benefit dies or lapses or his or her Policy or Certificate for any reason, the Issuer must retain the stipulated information for a period of at least five (5) years after the time when the Policy ceases to be in force. Unless notified by the Department of Health Services to the contrary during this period, after the five (5) years, the Service Summary provided by the Issuer will be deemed to comply with all Medi-Cal Property Exemption reporting, record keeping, auditing and quality control requirements of this rule. The Issuer may use microfiche, microfilm, optical storage media, or any other cost effective method of record storage as alternatives to storage of paper copies of stipulated information.

(c) At the time the Policy or Certificate ceases to be in force, the Issuer shall notify the Policy or Certificate holder of his or her right to request his or her service records as stipulated in subsection (f).

(d) The Issuer shall also, upon request in writing, provide such Policy or Certificate holder or the Policy or Certificate holder's Authorized Designee, if any, with a copy of the Issuer's service records as required in subsection (f) which are necessary to establish the Medi-Cal Property Exemption. These records shall be provided to the Policy or Certificate holder or the Policy or Certificate holder's Authorized Designee, if requested, within sixty (60) days of the request. The Issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

(e) The Issuer shall enclose with the records a statement advising the former Policy or Certificate holder that it is in his or her interest to retain the records if he or she may ever wish to establish eligibility for the Medi-Cal Program.

(f) The information to be maintained includes the following:
(1) evidence that the Benefit Eligibility has taken place;

(A) Benefit Eligibility must be documented by a Care Management Provider Agency, or its Qualified Official Designee, as part of the initial assessment of the client or as part of a subsequent reassessment.

(B) These assessments must be based on direct observations and interviews in conjunction with a medical record review. The Care Manager carrying out the assessment or their Care Management Supervisor must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

(2) description of services provided under the Policy or Certificate, including the following:

(A) name, address, phone number, and license number, if applicable, of provider;

(B) amount, date, and type of services provided, and whether the services qualify for Medi-Cal Property Exemption;

(C) dollar amounts paid by the Issuer, whether on an indemnity, expense incurred, or other basis;

(D) the charges of the service providers, including copies of invoices for all services counting towards Medi-Cal Property Exemption; and

(E) identification of the Care Management Provider Agency and copies of all assessments and reassessments.

(3) In order for services to qualify for a Medi-Cal Property Exemption, these services must be in accord with a Plan of Care developed by a Care Management Provider Agency. If the Policy or Certificate holder has received any benefits delivered as part of a Plan of Care, the Issuer must retain the following:

(A) a copy of the original Plan of Care; and

(B) a copy of any changes made in the Plan of Care. Such services shall count towards the Medi-Cal Property Exemption after the Care Management Provider Agency adds the documented need for and description of the new services to the Plan of Care. In cases when the service must begin before the revisions to the Plan of Care are made, the new services will only count towards a Medi-Cal Property Exemption if the revisions to the Plan of Care are made within ten (10) business days of the commencement of the new services. Care Management Provider Agencies must act upon requests for changes in the Plan of Care in an expeditious manner. Issuers must maintain initial assessments and subsequent reassessments as part of Benefit Eligibility documentation.

58079. Reporting to the Policy or Certificate Holder on the Medi-Cal Property Exemption.

(a) Each Issuer shall send a Medi-Cal Property Exemption Report (rev. 12/93) at least Quarterly to each Policy or Certificate holder for whom any benefit payments were made since the last Medi-Cal Property Exemption report. Each Medi-Cal Property Exemption report shall include the dollar amounts of benefits paid by the Policy or Certificate for the Policy or Certificate holder in the following order and for the periods specified:

(1) the cumulative amount of benefits paid prior to the current reporting period that counted towards the Medi-Cal Property Exemption;

(2) the amount paid during the current reporting period regardless of qualification for the Medi-Cal Property Exemption;

(3) the amount paid during the current reporting period that counts towards the Medi-Cal Property Exemption; and

(4) the total cumulative amount paid to date that counts towards the Medi-Cal Property Exemption (i.e., the amounts reported in (1)+(3)). This amount should be clearly indicated with a label "Medi-Cal Property Exemption To Date".

(5) the remaining benefit amount.

(b) The Medi-Cal Property Exemption report shall also include the following statement in bold type:

"This report provides you with a total amount of insurance payments, to date, which count towards the Medi-Cal Property Exemption for purposes of being eligible for the State of California's Medicaid (Medi-Cal) program. Please examine this report and carefully compare your current asset total with the amount indicated in this report with the label "Medi-Cal Property Exemption To Date." If your Property Exemption level is close to the amount of the assets you currently have, you may be eligible for the Medi-Cal program. It is your responsibility to make application to the County (usually the Department of Social Services); at the time of your application, a determination will be made whether and when you are eligible. (Please note: contact the appropriate County department regarding other exemptions of assets in addition to the Property level listed above.)"

58080. Preparing a Service Summary.

(a) Each Issuer shall prepare a Service Summary at the client's request specifically for the Policy or Certificate holder applying for Medi-Cal. The Issuer shall also prepare a Service Summary and sent it to the Policy or Certificate holder and the Department of Health Services when the Policy or Certificate holder has exhausted his or her benefits under the Policy or Certificate or when the Policy or Certificate ceases to be in force for a reason other than the death of the Policy or Certificate holder, whichever occurs first. This Service Summary will be in a standardized form and format prescribed by the Department of Health Services.

This Service Summary is prepared in addition to the information requirements described in Section 58078.

(b) Each Issuer shall notify the policy or certificate holder and the Care Manager Provider Agency one hundred twenty (120) days prior to the date when coverage for each Policy or Certificate is about to be exhausted. A copy of the Issuer's notification shall be forwarded to the Department of Health Services at the same time it is forwarded to the Care Manager Provider Agency.

58081. Plan of Action for Information and Document Maintenance.

(a) Each Issuer shall, prior to certification by the Department of Health Services, submit to the Department a plan for complying with the information maintenance and documentation requirements set forth in Article 6 of this Chapter. No Policy or Certificate shall be certified until the Department of Health Services has approved the Issuer's documentation plan for the Policy or Certificate. The documentation plan will include the following:

(1) the location where records will be kept. Records required for purposes of the California Partnership for Long-Term Care must be available at no more than three (3) locations, each of which shall be easily accessible to the California Partnership for Long-Term Care;

(2) the Issuer shall agree to give the Department of Health Services, or its appointed designee, access to all information described in Section 58078 of this Chapter on an aggregate basis and on an individual basis for all Policy or Certificate holders. Access to information on persons who have not applied for Medi-Cal is required in order for the Department of Health Services, or its appointed designee, to determine if an Issuer's system for documenting the Medi-Cal Property Exemption is functioning correctly. The Department of Health Services shall determine the frequency of access to the data and the size of samples for auditing purposes.

(3) the name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with the Department of Health Services concerning the information;

(4) methods for determining when insurance benefits or prepaid benefits qualify for the Medi-Cal Property Exemption, including the following:

(A) documentation of the Insured Event;

(B) description of services;

(C) documentation of charges and benefits paid; and

(D) documentation of Plans of Care;

(5) description of electronic and manual systems which will be used in maintaining the required information;

(6) information that will be retained which is needed to comply with this rule; and

(7) copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including the specific electronic medium which will be used to report required information and a description of the relevant files.

(b) After the Department of Health Services has approved a plan of action, the Department of Health Services shall advise the Department of Insurance and the Issuer in writing within five days.

(c) If the Department of Health Services disapproves a plan of action, the Department of Health Services shall within five (5) days advise the Issuer of the shortcomings in the plan of action and shall instruct the Issuer of the methods necessary to resolve them.

58082. Auditing and Correcting Deficiencies in Issuer Record Keeping.

(a) Within one (1) year of the first date that any Policy or Certificate holder of a particular Issuer's Policy or Certificate has met the criteria for Benefit Eligibility, and as often as the Department of Health Services deems necessary thereafter, the Department of Health Services, or its appointed designee, shall conduct a systems audit of that company's records. The Issuer shall be responsible for advising the Department of Health Services when this one (1) year period has begun. The Department of Health Services, or its appointed designee, shall inform each Issuer of inaccuracies and other potential problems discovered in its systems audits, and the Issuer shall correct any problems in its methods of operation.

(b) The Department of Health Services shall periodically reconcile a sample of individual applications for Medi-Cal of persons who have submitted documentation for qualification for the Medi-Cal Property Exemption with the reports submitted by Issuers. The Department shall have the final decision concerning sample sizes and other auditing methods. The Department of Health Services shall promptly advise Issuers of any problems discovered, and the Issuer shall correct any problems in its method of operation. The Department of Health Services shall also notify the Issuer of any obligations described in this Chapter to hold clients harmless.

(c) The Department of Health Servicers may enter into voluntary arrangements with Issuers of Partnership Long-Term Care Insurance Policies and Certificates under which the Department of Heath Services would issue binding determinations as to whether or not services qualify for a Medi-Cal Property Exemption. Requests for information and advice from Policy or Certificate holders shall be directed through their Issuer or Care Management Provider Agency. When the procedures in this section are followed, the written determinations of the Department of Health Services concerning whether services qualify for a Medi- Cal Property Exemption shall be binding upon the Department of Health Services in all subsequent actions, and the Department of Health Services shall not make any assertion contradicting these determinations in any action arising in this subsection:

(1) All requests for determinations as to whether or not services qualify for a Medi-Cal Property Exemption shall be submitted to the California Partnership for Long-Term Care in writing. These requests may include, but are not limited to, requests for determinations in the following areas:

(A) whether Benefit Eligibility has occurred and has been adequately documented;

(B) whether a revision of a Plan of Care is required;

(C) whether a service or services are in accord with the Plan of Care;

(D) whether a service is of such a nature as to qualify for a Medi-Cal Property Exemption; and

(E) whether the applicable amount is the amount paid by the Issuer or the amount charged for the service.

(2) The California Partnership for Long-Term Care may require Issuers and Care Management Provider Agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information shall include, but are not limited to, the following:

(A) assessments;

(B) Plans of Care;

(C) invoices for services rendered;

The Issuer providing the records and other information shall be responsible for their accuracy. If any records or other information are later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on the Department of Health Services, or any other person or entity in subsequent actions. In the case of a Policy or Certificate holder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of subsections (e) and (f) will apply in the same manner as for any other Policy or Certificate holder.

(3) The California Partnership on Long-Term Care shall render its determination on each request in writing within thirty (30) days of receiving the request. Each determination of the California Partnership for Long-Term Care shall state the reason(s) for it's determination, including the following:

(A) relevant facts;

(B) documentation of facts;

(C) statutes;

(D) regulations; and

(E) policies;

(4) A copy of all determinations of the California Partnership for Long-Term Care shall be kept on file at the Department of Health Services, together with the related records and information. The original of the determination shall be sent to the Issuer or the Care Management Provider Agency who originally requested it. The receipt of the original determination shall be responsible for notifying the Policy or Certificate holder or the Policy or Certificate holder's authorized agent.

(d) When an audit or other review by the Department of Health Services, or its appointed designee, reveals deficiencies in the record keeping procedures of an Issuer, the Department of Health Services will notify the Issuer of the deficiencies and establish a reasonable deadline for correction.

(e) If an Issuer prepares a Service Summary which is used in a Medi-Cal application for a Policy or Certificate holder and the client is found eligible for Medi-Cal, and the Policy or Certificate holder after receiving Medi-Cal services is found to be ineligible for Medi-Cal solely by reason of errors in the Issuer's Service Summary or documentation of services, the Department of Health Services may require the Issuer to pay for services counting towards the Medi-Cal Property Exemption required by the Policy or Certificate holder until the Issuer has paid an amount equal to the amount of the Issuer's errors; after which the Policy or Certificate holder, if otherwise eligible, could qualify for Medi-Cal coverage.

(f) If the Department of Health Services determines that an Issuer's record pertaining to a Policy or Certificate holder who has received Medi-Cal benefits are in such condition that the Department of Health Services cannot determine whether the Policy or Certificate holder qualifies for a Medi-Cal Property Exemption, the Department of Health Services may require the Issuer to pay for services counting towards the Medi-Cal Property Exemption required by the Policy or Certificate holder until the Issuer has paid an amount equal to the amount of the services which could not be determined; after which, the Policy or Certificate holder, if otherwise eligible, could qualify for Medi-Cal coverage.

(g) Compliance with subsections (e) and (f) is a requirement for a Policy or Certificate to retain certification.

59998. Medical Supplies.

(a) Medical supplies covered under section 51320 and payable under section 51520 shall be subject to the following requirements.

(1) Code I items, marked with a single asterisk (*), shall:

(A) Require prior authorization in accordance with section 51003 unless used under the conditions individually specified.

(B) Be subject to the prescription documentation requirements of section 51476(c).

(2) Items listed in subsection (b) shall be subject to quantity and patient age limitations.

(3) Items not listed in subsection (b) shall require prior authorization in accordance with section 51003. Authorization may be granted if:

(A) The clinical condition of the patient requires the use of an unlisted item and listed items have been adequately considered or tried and are not effective.

(B) The use of an unlisted item results in a less expensive treatment than would otherwise occur.

(4) Medical supplies provided to inpatients receiving nursing facility level B services or nursing facility level A services shall be reimbursed only if the item is:

(A) Marked with a double asterisk (**). An exception to this requirement is incontinence medical supplies provided to residents of Intermediate Care Services for the Developmentally Disabled/Habilitative facilities or Intermediate Care Services for the Developmentally Disabled-Nursing facilities pursuant to Sections 51510.2 and 51510.3, Title 22, California Code of Regulations.

(B) Required for exclusive use by a specific patient.

(5) Medical supplies provided to inpatients receiving hospital acute care services are included in reimbursements made under section 51536 and are not separately payable.

(6) Medical supplies for chronic outpatient hemodialysis provided in renal dialysis centers, community hemodialysis units or for home dialysis are covered, but are payable only when included in the all inclusive facility rate set forth in section 51509.2.

(7) The following items, and supplies not primarily medical in nature, are not covered by the program.

(A) Common household items.

(B) Articles of clothing.

(C) Toothbrushes, toothpaste and denture cleaners.

(D) Shaving soap and lotions.

(E) Cigarettes, cigars, pipes and tobacco.

(F) Cosmetics.

(G) Hair combs and brushes.

(H) Tissue wipes.

(I) Cotton, adhesive tapes and elastic bandages.

(b) The following items may be provided without prior authorization if requirements of subsection (a) and requirements specified for individual items are met.

ALCOHOL, ISOPROPYL
Solution, 91% or 99
ASPIRATOR, NASAL SEE SYRINGE, BULB
BANDAGES, NONMEDICATED OR MEDICATED
Dressing Type
Gauze Type
Pad Type
[FNa1] Sanitary Napkin/Tampon Type
[FNa1] Restricted to use in postpartum bleeding/drainage, hemorrhoid bleeding and wound bleeding/drainage.
Sponge Type
BREAST PUMP, BULB TYPE
CATHETERS, URINARY SEE URINARY DRAINAGE AND IRRIGATION SUPPLIES
CLYSIS SEE HYPODERMOCLYSIS ADMINISTRATION SET
COLOSTOMY SUPPLIES SEE OSTOMY SUPPLIES
[FNaa1] CONDOMS
[FNaa1] CONTRACEPTIVE CREAM, FOAM, JELLY, OR SUPPOSITORY
COVER PADS OR SPONGES SEE BANDAGES
[FNaa1] DIABETIC TESTS
Reagent Strips or Tape
Reagent Tablets or Tablet Set
DIAPERS, DISPOSABLE SEE INCONTINENCE MEDICAL SUPPLIES
[FNaa1] DIAPHRAGM
Diaphragm

Kit
DRESSINGS SEE BANDAGES
EAR SYRINGE SEE SYRINGE, BULB
EYE PADS SEE BANDAGES
FEEDING TUBE
FISTULA SUPPLIES SEE OSTOMY SUPPLIES
FOUNTAIN SYRINGE (Limit of one per patient)
GAUZE BANDAGE SEE BANDAGES
[FNa1] GLOVES, DISPOSABLE
Nonsterile (Limit of 100 per prescription)
[FNa1] Restricted to use in paraplegia or quadriplegia bowel procedures, and the cleaning of body fluids and wastes for patients with Acquired Immune Deficiency Syndrome.
HOT WATER BOTTLE (Limit of one per patient)
HEPARIN LOCK CAPS
HYPODERMIC NEEDLES SEE NEEDLES, HYPODERMIC
HYPODERMIC SYRINGES SEE SYRINGE, HYPODERMIC
[FNaa1] HYPODERMOCLYSIS ADMINISTRATION SET
ILEOSTOMY SUPPLIES SEE OSTOMYSUPPLIES
[FNa1] INCONTINENCE MEDICAL SUPPLIES (Limited to patients of age 5 or greater)
Diapers, Disposable
Pants (Limit of 2 per prescription)
Pant Liners, Disposable
Underpads, Disposable
[FNa1] Restricted to use in chronic pathologic conditions causally related to the patient's incontinence, and the cost to the program does not exceed $165.00 per month.
[FNaa1] INTRAVENOUS SOLUTIONS ADMINISTRATION SET
INVALID CUSHION
[FNaa1] KARAYA GUM POWDER
LEVINE TUBE SEE FEEDING TUBE
LUBRICATING JELLY, STERILE
NEBULIZER, BULB TYPE
NEEDLES, HYPODERMIC
Disposable
Reusable
OSTOMY SUPPLIES
PADS, STERILE SEE BANDAGES
SANITARY NAPKINS/TAMPONS SEE BANDAGES
SHEETING, WATERPROOF
SPONGES, STERILE SEE BANDAGES
SUSPENSORY
[FNa1] SWABSTICKS, SATURATED (3 swab sealed package only)
Povidone-Iodine Scrub

70% Isopropyl alcohol
[FNa1] Restricted to use for cleansing the skin at central or peripheral
catheter exit
site during dressing changes and for intravenous
starts.
SYRINGE, BULB TYPES
SYRINGE, HYPODERMIC
Disposable
Reusable
SYRINGE WITH NEEDLE
Disposable
THERMOMETER
TRACHEOSTOMY SUPPLIES SEE OSTOMY SUPPLIES
URINARY DRAINAGE/IRRIGATION SUPPLIES
UROSTOMY SUPPLIES SEE OSTOMY SUPPLIES AND
URINARY DRAINAGE/
IRRIGATION SUPPLIES
VAPORIZER

[FNa1] Code I. See section 59998(a)(1) regarding prior authorization and section 51476(c) regarding prescription documentation requirements.

[FNaa1] See section 59998(a)(4) regarding coverage for inpatients receiving skilled nursing facility services or intermediate care facility services.

59998. Medical Supplies.

(a) Medical supplies covered under section 51320 and payable under section 51520 shall be subject to the following requirements.

(1) Code I items, marked with a single asterisk (*), shall:

(A) Require prior authorization in accordance with section 51003 unless used under the conditions individually specified.

(B) Be subject to the prescription documentation requirements of section 51476(c).

(2) Items listed in subsection (b) shall be subject to quantity and patient age limitations.

(3) Items not listed in subsection (b) shall require prior authorization in accordance with section 51003. Authorization may be granted if:

(A) The clinical condition of the patient requires the use of an unlisted item and listed items have been adequately considered or tried and are not effective.

(B) The use of an unlisted item results in a less expensive treatment than would otherwise occur.

(4) Medical supplies provided to inpatients receiving nursing facility level B services or nursing facility level A services shall be reimbursed only if the item is:

(A) Marked with a double asterisk (**). An exception to this requirement is incontinence medical supplies provided to residents of Intermediate Care Services for the Developmentally Disabled/Habilitative facilities or Intermediate Care Services for the Developmentally Disabled-Nursing facilities pursuant to Sections 51510.2 and 51510.3, Title 22, California Code of Regulations.

(B) Required for exclusive use by a specific patient.

(5) Medical supplies provided to inpatients receiving hospital acute care services are included in reimbursements made under section 51536 and are not separately payable.

(6) Medical supplies for chronic outpatient hemodialysis provided in renal dialysis centers, community hemodialysis units or for home dialysis are covered, but are payable only when included in the all inclusive facility rate set forth in section 51509.2.

(7) The following items, and supplies not primarily medical in nature, are not covered by the program.

(A) Common household items.

(B) Articles of clothing.

(C) Toothbrushes, toothpaste and denture cleaners.

(D) Shaving soap and lotions.

(E) Cigarettes, cigars, pipes and tobacco.

(F) Cosmetics.

(G) Hair combs and brushes.

(H) Tissue wipes.

(I) Cotton, adhesive tapes and elastic bandages.

(b) The following items may be provided without prior authorization if requirements of subsection (a) and requirements specified for individual items are met.

ALCOHOL, ISOPROPYL
Solution, 91% or 99
ASPIRATOR, NASAL SEE SYRINGE, BULB
BANDAGES, NONMEDICATED OR MEDICATED
Dressing Type
Gauze Type
Pad Type
[FNa1] Sanitary Napkin/Tampon Type
[FNa1] Restricted to use in postpartum bleeding/drainage, hemorrhoid bleeding and wound bleeding/drainage.
Sponge Type
BREAST PUMP, BULB TYPE
CATHETERS, URINARY SEE URINARY DRAINAGE AND IRRIGATION SUPPLIES
CLYSIS SEE HYPODERMOCLYSIS ADMINISTRATION SET
COLOSTOMY SUPPLIES SEE OSTOMY SUPPLIES
[FNaa1] CONDOMS
[FNaa1] CONTRACEPTIVE CREAM, FOAM, JELLY, OR SUPPOSITORY
COVER PADS OR SPONGES SEE BANDAGES
[FNaa1] DIABETIC TESTS
Reagent Strips or Tape
Reagent Tablets or Tablet Set
DIAPERS, DISPOSABLE SEE INCONTINENCE MEDICAL SUPPLIES
[FNaa1] DIAPHRAGM
Diaphragm

Kit
DRESSINGS SEE BANDAGES
EAR SYRINGE SEE SYRINGE, BULB
EYE PADS SEE BANDAGES
FEEDING TUBE
FISTULA SUPPLIES SEE OSTOMY SUPPLIES
FOUNTAIN SYRINGE (Limit of one per patient)
GAUZE BANDAGE SEE BANDAGES
[FNa1] GLOVES, DISPOSABLE
Nonsterile (Limit of 100 per prescription)
[FNa1] Restricted to use in paraplegia or quadriplegia bowel procedures, and the cleaning of body fluids and wastes for patients with Acquired Immune Deficiency Syndrome.
HOT WATER BOTTLE (Limit of one per patient)
HEPARIN LOCK CAPS
HYPODERMIC NEEDLES SEE NEEDLES, HYPODERMIC
HYPODERMIC SYRINGES SEE SYRINGE, HYPODERMIC
[FNaa1] HYPODERMOCLYSIS ADMINISTRATION SET
ILEOSTOMY SUPPLIES SEE OSTOMYSUPPLIES
[FNa1] INCONTINENCE MEDICAL SUPPLIES (Limited to patients of age 5 or greater)
Diapers, Disposable
Pants (Limit of 2 per prescription)
Pant Liners, Disposable
Underpads, Disposable
[FNa1] Restricted to use in chronic pathologic conditions causally related to the patient's incontinence, and the cost to the program does not exceed $165.00 per month.
[FNaa1] INTRAVENOUS SOLUTIONS ADMINISTRATION SET
INVALID CUSHION
[FNaa1] KARAYA GUM POWDER
LEVINE TUBE SEE FEEDING TUBE
LUBRICATING JELLY, STERILE
NEBULIZER, BULB TYPE
NEEDLES, HYPODERMIC
Disposable
Reusable
OSTOMY SUPPLIES
PADS, STERILE SEE BANDAGES
SANITARY NAPKINS/TAMPONS SEE BANDAGES
SHEETING, WATERPROOF
SPONGES, STERILE SEE BANDAGES
SUSPENSORY
[FNa1] SWABSTICKS, SATURATED (3 swab sealed package only)
Povidone-Iodine Scrub

70% Isopropyl alcohol
[FNa1] Restricted to use for cleansing the skin at central or peripheral catheter exit site during dressing changes and for intravenous starts.
SYRINGE, BULB TYPES
SYRINGE, HYPODERMIC
Disposable
Reusable
SYRINGE WITH NEEDLE
Disposable
THERMOMETER
TRACHEOSTOMY SUPPLIES — SEE OSTOMY SUPPLIES
URINARY DRAINAGE/IRRIGATION SUPPLIES
UROSTOMY SUPPLIES — SEE OSTOMY SUPPLIES AND URINARY DRAINAGE/IRRIGATION SUPPLIES
VAPORIZER

[FNa1] Code I. See section 59998(a)(1) regarding prior authorization and section 51476(c) regarding prescription documentation requirements.

[FNaa1] See section 59998(a)(4) regarding coverage for inpatients receiving skilled nursing facility services or intermediate care facility services.